DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

CMS-1393-F and CMS-1199-F

RINs 0938-AO94 and 0938-AN87

Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2009: Annual Payment Rate Updates, Policy Changes, and Clarifications; and Electronic Submission of Cost Reports: Revision to Effective Date of Cost Reporting Period

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

ACTION: Final rule.

SUMMARY: This final rule updates the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). We are also consolidating the annual July 1 update for payment rates and the October 1 update for Medicare severity long-term care diagnosis-related group (MS-LTC-DRG) weights to a single rulemaking cycle that coincides with the Federal fiscal year (FFY). In addition, we are clarifying various policy issues.

This final rule also finalizes the provisions from the Electronic Submission of Cost Reports: Revision to Effective Date of Cost Reporting Period interim final rule with comment period that was published in the May 27, 2005 **Federal Register** which revises the existing effective date by which all organ procurement organizations (OPOs), rural health clinics (RHCs), Federally qualified health centers (FQHCs), and community mental health centers (CMHCs) are required to submit their Medicare cost reports in a standardized electronic format from cost reporting periods ending on or after December 31, 2004 to cost reporting periods ending on or after March 31, 2005. This final rule does not affect the current cost reporting requirement for hospices and end-stage renal disease (ESRD) facilities. Hospices and ESRD facilities are required to continue to submit cost reports under the Medicare regulations in a standardized electronic format for cost reporting periods ending on or after December 31, 2004.

DATES: The provisions of this final rule are effective on [OFR—insert date 60 days after the date of filing for public inspection at OFR.]

FOR FURTHER INFORMATION CONTACT:

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

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

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

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

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

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

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

Darryl E. Simms, (410) 786-4524 (Electronic Submission of Cost Reports: Revision to Effective Date of Cost Reporting Period).

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Acronyms

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

3M	3M Health Information System
AHA	American Hospital Association
AHIMA	American Health Information Management Association
ALOS	Average length of stay
ALTHA	Acute Long Term Hospital Association
ASCA	Administrative Simplification Compliance Act of 2002 (Pub. L. 107-105)
BBA	Balanced Budget Act of 1997 (Pub. L. 105-33)

BBRA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106-113)
BIPA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554)
BLS	Bureau of Labor Statistics
BN	Budget neutrality
CBSA	Core-based statistical area
CC	Complications and comorbidities
CCR	Cost-to-charge ratio
C&M	Coordination and maintenance
CMI	Case-mix index
CMS	Centers for Medicare & Medicaid Services
COLA	Cost of living adjustment
COP	Condition of participation
CPI	Consumer Price Index
CY	Calendar year
DSH	Disproportionate share of low-income patients
DRGs	Diagnosis-related groups
ECI	Employment Cost Index
FI	Fiscal intermediary
FY	Fiscal year
FFY	Federal fiscal year

HCO	High-cost outlier
HCRIS	Hospital cost report information system
HHA	Home health agency
HHS	(Department of) Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act (Pub. L. 104-191)
HIPC	Health Information Policy Council
HwHs	Hospitals within hospitals
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification (codes)
IME	Indirect medical education
I-O	Input-Output
IPF	Inpatient psychiatric facility
IPPS	[Acute Care Hospital] Inpatient Prospective Payment System
IRF	Inpatient rehabilitation facility
LOS	Length of stay
LTC-DRG	Long-term care diagnosis-related group
LTCH	Long-term care hospital
MAC	Medicare Administrative Contractor
MCE	Medicare code editor
MDC	Major diagnostic categories
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare provider analysis and review

MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173)
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173)
MSA	Metropolitan statistical area
MS-DRG	Medicare severity diagnosis-related group
MS-LTC-DRG	Medicare severity long-term care diagnosis-related group
NAICS	North American Industrial Classification System
NALTH	National Association of Long Term Hospitals
NCHS	National Center for Health Statistics
OACT	[CMS'] Office of the Actuary
OBRA 86	Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509)
OMB	Office of Management and Budget
OPM	U.S. Office of Personnel Management
O.R.	Operating room
OSCAR	Online Survey Certification and Reporting (System)
PIP	Periodic interim payment
PLI	Professional liability insurance
PMSA	Primary metropolitan statistical area
PPI	Producer Price Indexes
PPS	Prospective payment system
PSF	Provider specific file
QIO	Quality Improvement Organization (formerly Peer Review organization (PRO))

RIA	Regulatory impact analysis
RPL	Rehabilitation psychiatric long-term care (hospital)
RTI	Research Triangle Institute, International
RY	Rate year (begins July 1 and ends June 30)
SIC	Standard industrial code
SNF	Skilled nursing facility
SSO	Short-stay outlier
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248)
TEP	Technical expert panel
UHDDS	Uniform hospital discharge data set

I. Background of the LTCH PPS

A. Legislative and Regulatory Authority

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

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than

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

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

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

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

The LTCH PPS replaced the reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248) for payments for

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

In the August 30, 2002 final rule, we also presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the BN requirements mandated by section 123 of the BBRA. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, subpart O, also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements. We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS (67 FR 55954).

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

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110-173) that was enacted on December 29, 2007 has various effects on the LTCH PPS. The new law's provisions also have varying timeframes of applicability. First, we note that certain provisions of the MMSEA provided that Secretary shall not apply, for cost reporting periods beginning on or after the date of the enactment of the MMSEA (December 29, 2007) for a 3-year period: the extension of payment adjustments at §412.534 to "grandfathered LTCHs" (a long term care hospital identified by the amendment made by section 4417(a) of Pub. L. 105-33); and the payment adjustment at §412.536 to "freestanding" LTCHs. In addition, the new law provides that the Secretary shall not apply, for the 3-year period beginning on the date of enactment of the Act the revision to the SSO policy that was finalized in the rate year RY 2008 LTCH

PPS final rule (72 FR 26904 and 26992) and the one-time adjustment to the payment rates provided for in §412.523(d)(3). The statute also provides that the base rate for RY 2008 be the same as the base rate for RY 2007 (the revised base rate, however, does not apply to discharges occurring on or after July 1, 2007 and before April 1, 2008); for a 3-year moratorium (with specified exceptions) on the establishment of new LTCHs, LTCH satellites, and on the increase in the number of LTCH beds. The new law also revises in the threshold percentages for certain co-located LTCHs and LTCH satellites governed under §412.534. Finally, the MMSEA provides for an expanded review of medical necessity for admission and continued stay at LTCHs. In this final rule, we are establishing the applicable Federal rates for RY 2009 consistent with section 1886(m)(2) of the Act as amended by MMSEA. We are also revising the regulations at §412.523(d)(3) to change the methodology for the one-time budget neutrality adjustment and to comply with section 114(c)(4) of the MMSEA. Other policy revisions necessitated by the statutory changes of the MMSEA were addressed in separate rulemaking document and other provisions required by this new law will be addressed in the future.

B. Criteria for Classification as a LTCH

1. Classification as a LTCH

Under the existing regulations at §412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient LOS of greater than 25 days. Alternatively, §412.23(e)(2)(ii) states that for cost reporting periods beginning on or after August 5, 1997, a hospital that was

first excluded from the PPS in 1986 and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient LOS for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days.

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

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

two or more separate consecutive cost reporting periods, the total number of days of the stay are considered to have occurred in the cost reporting period during which the inpatient was discharged.

Fiscal intermediaries (FIs) verify that LTCHs meet the ALOS requirements. We note that the inpatient days of a patient who is admitted to a LTCH without any remaining Medicare days of coverage, regardless of the fact that the patient is a Medicare beneficiary, will not be included in the above calculation. Because Medicare would not be paying for any of the patient's treatment, data on the patient's stay would not be included in the Medicare claims processing systems. In order for both covered and noncovered days of a LTCH hospitalization to be included, a patient admitted to the LTCH must have at least 1 remaining benefit day (68 FR 34123).

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

As we stated in the FY 2004 Hospital Inpatient Prospective Payment System (IPPS) final rule, published in the August 1, 2003 **Federal Register**, prior to the implementation of the LTCH PPS, we did rely on data from the most recently submitted

cost report for purposes of calculating the ALOS (68 FR 45464). The calculation to determine whether an acute care hospital qualifies for LTCH status was based on total days and discharges for LTCH inpatients. However, with the implementation of the LTCH PPS, for the ALOS specified under §412.23(e)(2)(i), we revised §412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (67 FR 55970 through 55974). In addition, the ALOS specified under §412.23(e)(2)(ii) is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period. As we discussed in the FY 2004 IPPS final rule, we are unable to capture the necessary data from our existing cost reporting forms (68 FR 45464). Therefore, we notified FIs and LTCHs that until the cost reporting forms are revised, for purposes of calculating the ALOS, we will be relying upon census data extracted from Medicare Provider Analysis and Review (MedPAR) files that reflect each LTCH's cost reporting period (68 FR 45464). Requirements for hospitals seeking classification as LTCHs that have undergone a change in ownership, as described in §489.18, are set forth in §412.23(e)(3)(iv).

2. Hospitals Excluded from the LTCH PPS

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

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.

- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90-248) (42 U.S.C. 1395b-1) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92-603) (42 U.S.C. 1395b-1 (note)) (Statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).

- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

C. Transition Period for Implementation of the LTCH PPS

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

D. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH PPS (67 FR 55974 through 55975). In the RY 2005 LTCH PPS final rule (69 FR 25676), we clarified that the discussion of beneficiary liability in the August 30, 2002 final rule was not meant to establish rates or payments for, or define Medicare-eligible expenses. Under §412.507, if the Medicare payment to the LTCH is the full LTC-DRG payment amount, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under §409.82, §409.83,

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

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

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

II. Summary of the Provisions of this Final Rule

The RY 2009 proposed rule appeared in the Federal Register (73 FR 5342) on January 29, 2008. We received 18 timely items of correspondence on the proposed rule that we respond to in the appropriate sections of this final rule. We also received one comment that addressed our policy on satellites of LTCHs that is beyond the scope of this regulation. Also beyond the scope of this regulation was a comment directed to our interpretation of the "25 percent threshold policy" revisions, one of the requirements specified in 114 of the MMSEA, provisions of which will be addressed in a future rulemaking.

In this final rule, we are revising the LTCH PPS payment rate update cycle and making other policy changes and clarifications. The following is a summary of the major areas that we are addressing in this final rule.

In section III. of this final rule, we discuss the LTCH PPS patient classification and the relative weights which are linked to the annual adjustments of the acute care hospital inpatient DRG system, and are based on the annual revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes effective each October 1. In this section, we also summarize the severity adjusted MS-LTC-DRGs and the development of the relative weights for FY 2008 as established in the FY 2008 IPPS final rule with comment period as well as the proposed update to the MS-LTC-DRGs and relative weights for FY 2009 presented in the FY 2009 IPPS proposed rule.

In section IV.B. of this final rule, we are extending the rate year cycle for RY 2009 to a 15-month period, from July 1, 2008 through September 30, 2009. We will

continue to have an update to the MS-LTC-DRG classifications and weights effective for October 1, 2008. We are consolidating the annual update to the payment rates and the update of the MS-LTC classifications and weights beginning October 1, 2009.

As discussed in section IV.E.2. of this final rule, we are establishing a 2.7 percent update to the LTCH PPS Federal rate for the 2009 LTCH PPS rate year based on the most recent market basket estimate for the 15-month 2009 LTCH PPS rate year and an adjustment to account for improvements in coding and documentation. Also in section IV. of this final rule, we discuss the prospective payment rate for RY 2009.

In section IV. D. of this final rule, we discuss the possible one-time adjustment to the Federal payment rate under §412.523(d)(3). Consistent with section 114(c)(4) of MMSEA, we did not propose any adjustment under §412.523(d)(3). However, at this time, we are revising the regulations to clarify the objectives of the possible one-time adjustment, to more precisely reflect the methodology, and to reflect the requirements of section 114(c)(4) of the MMSEA to the regulatory text.

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

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

In section VIII. of this final rule, we discuss Research Triangle Institute's (RTI) analysis relating to the development of LTCH patient-and facility-level criteria.

In section IX. of this final rule, we are finalizing the revision to the effective date of cost reporting periods for electronic submission of cost reports for certain entities.

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

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

A. Background

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

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

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the Medicare Severity diagnosis related groups (MS-DRGs) and the Medicare Severity long-term care diagnosis related groups (MS-LTC-DRGs) were adopted for the IPPS and the LTCH PPS, respectively, effective October 1, 2007 (FY 2008). For a full description of the development and implementation of the MS-DRGs and MS-LTC-DRGs, see the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that in that same final rule, we revised the regulations at §412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of this subpart for policy descriptions and payment calculations, all references to LTC-DRGs would be considered a reference to MS-LTC-DRGs. For the remainder of this section, we present the discussion in terms of the current MS-LTC-DRG patient classification unless specifically referring to the previous LTC-DRG patient classification system (that was in effect before October 1, 2007).) We believe the MS-DRGs (and by extension, the MS-LTC-DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

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

We have generally retained all of the refinements and improvements that have been made to the base DRGs over the years that recognize the significant advancements in medical technology and changes to medical practice.

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

In a departure from the IPPS, we use low volume MS-LTC-DRGs (less than 25 LTCH cases) in determining the MS-LTC-DRG relative weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. To manage the large number of low volume MS-LTC-DRGs (all MS-LTC-DRGs with fewer than 25 LTCH cases), for purposes of determining the relative weights, we group low volume MS-LTC-DRGs into 5 quintiles based on average charge per discharge. (A detailed discussion of the application of the Lewin Group "quintile" model that was used to develop the LTC-DRGs appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).) We also account for adjustments to payments for short-stay outlier (SSO) cases (that is, cases where the covered length of stay (LOS) at the LTCH is less than or equal to five-sixths of the geometric ALOS for the MS-LTC-DRG). Furthermore, we make adjustments to account for nonmonotonically increasing weights, when

necessary (as described below in this section). That is, theoretically, cases under the MS LTC DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, weights should increase monotonically with severity, from the lowest to highest severity level.

B. Patient Classifications into MS-LTC-DRGs

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

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

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of subparts A and I through R of part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health

Care Claim: Institutional, Volumes 1 and 2, version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction (see 45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD-9-CM Coding System, refer to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the Coding Clinic for ICD-9-CM.

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

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.69, Other and unspecified radical abdominal hysterectomy, would be an inappropriate code for a male.)

- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a non-approved transplant center.)

- Cases requiring more information. (For example, ICD-9-CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 262, Other severe protein-calorie malnutrition, contains

all appropriate digits, but if it is reported with either fewer or more than 3 digits, the claim will be rejected by the MCE as invalid.)

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

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS-DRG classification changes and to recalibrate the MS-DRG and MS-LTC-DRG relative weights during CMS' annual update under both the IPPS (§412.60(e)) and the LTCH PPS (§412.517), respectively. As discussed in greater detail in section III.D. of this preamble, with the implementation of section 503(a) of the MMA, there is the possibility that one feature of the GROUPER software program may be

updated twice during a Federal FY (FFY) (October 1 and April 1) as required by the statute for the IPPS (69 FR 48954 through 48957). The use of the ICD-9-CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162, published in accordance with HIPAA.

C. Organization of the MS-LTC-DRGs

The MS-DRGs (used under the IPPS) and the MS-LTC-DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted above in this section, we refer to the DRGs under the LTCH PPS as MS-LTC-DRGs although they are structurally identical to the DRGs used under the IPPS. The MS-DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD-9-CM procedure codes as procedures affecting DRG assignment, that is, procedures which are not surgical (for example, EKG), or minor surgical procedures (for example, 86.11, Biopsy of skin and subcutaneous tissue).

In developing Version 25.0 of the GROUPER program (the FY 2008 MS-DRGs), the diagnoses comprising the CC list were completely redefined. The revised CC list is primarily comprised of significant acute disease, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases, and chronic diseases associated with extensive debility. In general, most chronic diseases were not included on the

revised CC list. For a patient with a chronic disease, a significant acute manifestation of the chronic disease was required to be present and coded for the patient to be assigned a CC.

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

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

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

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

1. Background

Under the LTCH PPS, relative weights for each MS-LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (that is, the MS-LTC-DRGs). To ensure that Medicare

patients classified to each MS-LTC-DRG have access to an appropriate level of services and to encourage efficiency, each year based on the best available data, we calculate a relative weight for each MS-LTC-DRG that represents the resources needed by an average inpatient LTCH case in that MS-LTC-DRG. For example, cases in a MS-LTC-DRG with a relative weight of 2 will, on average, cost twice as much as cases in a MS-LTC-DRG with a relative weight of 1. Under §412.517, the MS-LTC-DRG classifications and weighting factors (that is, relative weights) are adjusted annually to reflect changes in factors affecting the relative use of LTCH resources, including treatment patterns, technology and number of discharges.

In the June 6, 2003 LTCH PPS final rule (68 FR 34122 through 34125), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, because the patient classification system utilized under the LTCH PPS is the same DRG system that is used under the IPPS, in that same final rule, we explained that the annual update of the LTC-DRG classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the CMS DRGs used under the IPPS (as is the case with the MS-DRGs effective for discharges occurring on or after October 1, 2007 (see §412.503)). Therefore, we specified that we will continue to update the LTC-DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. We further stated at that time that we will publish the annual proposed and final update of the LTC-DRGs in same notice as the proposed and final update for the IPPS (69 FR 34125). (We note that in section IV.B. of this preamble, we are proposing to revise §412.535 in order to consolidate the annual July

1 and October 1 LTCH PPS update cycles, so that beginning with FY 2010, both the annual update to the standard Federal rate (and other rate and policy changes) and the annual update to the MS-LTC-DRGs would be presented in a single **Federal Register** publication to be effective on October 1 each year.) Under existing §412.535(b), the FY 2008 update of the LTCH PPS patient classification system and relative weights was presented in the FY 2008 IPPS final rule with comment (72 FR 47277 through 47299). For the reader's benefit, we are providing a summary of the discussion presented in that final rule with comment in section III.D.2. of this preamble.

For FY 2008, the MS-LTC-DRG classifications and relative weights were updated based on LTCH data from the FY 2006 MedPAR file, which contained hospital bills data from the March 2007 update. The MS-LTC-DRG patient classification system for FY 2008 consists of 745 DRGs that formed the basis of the Version 25.0 GROUPER program utilized under the LTCH PPS. The 745 MS-LTC-DRGs included two "error DRGs." As in the IPPS, we included two error DRGs in which cases that cannot be assigned to valid DRGs will be grouped. These two error DRGs are MS-LTC-DRG 998 (Principal Diagnosis Invalid as a Discharge Diagnosis) and MS-LTC-DRG 999 (Ungroupable). The other 743 MS-LTC-DRGs are the same DRGs used in the IPPS GROUPER program for FY 2008 (Version 25.0).

In the past, the annual update to the CMS DRGs was based on the annual revisions to the ICD-9-CM codes and was effective each October 1. The ICD-9-CM coding update process was revised as discussed in greater detail in the FY 2005 IPPS final rule (69 FR 48953 through 48957). Specifically, section 503(a) of the MMA includes a requirement for updating diagnosis and procedure codes twice a year instead

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

As we explained in the FY 2008 IPPS final rule with comment period (72 FR 47277), annual changes to the ICD-9-CM codes historically were effective for discharges occurring on or after October 1 each year. Thus, the manual and electronic versions of the GROUPER software, which are based on the ICD-9-CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. The patient classification system used under the LTCH PPS (MS-LTC-DRGs) is the same DRG patient classification system used under the IPPS, which historically had been updated annually and was effective for discharges occurring on or after October 1

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

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

2. FY 2008 MS-LTC-DRG Relative Weights

In accordance with §412.523(c), we adjust the LTCH PPS standard Federal rate by the MS-LTC-DRG relative weights in determining payment to LTCHs for each case. Relative weights for each MS-LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups as described in §412.515. To ensure that Medicare patients who are classified to each MS-LTC-DRG have access to services and to encourage efficiency, we calculate a relative weight for each MS-LTC-DRG that represents the resources needed by an average inpatient LTCH case in that MS-LTC-DRG. For example, cases in a MS-LTC-DRG with a relative weight of 2 will, on average, cost twice as much as cases in a MS-LTC-DRG with a weight of 1.

As we discussed in the FY 2008 IPPS final rule with comment period (72 FR 47282), the MS-LTC-DRG relative weights effective under the LTCH PPS for Federal FY 2008 were calculated using the March 2007 update of FY 2006 MedPAR data which contains hospital bills received through March 31, 2007, and Version 25.0 of the GROUPER software.

LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation or wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have relatively high or relatively low charges. Distribution of cases with relatively high (or low) charges in specific MS-LTC-DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value (HSRV) method to calculate relative weights. We believe this method removes this hospital-specific source of bias in measuring average charges. Specifically, we reduce

the impact of the variation in charges across providers on any particular MS-LTC-DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge. (See the FY 2008 IPPS final rule with comment period for further information on the application of the HSRV methodology under the LTCH PPS (72 FR 47282).)

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

After grouping the cases in the appropriate MS-LTC-DRG, generally, we calculated the relative weights by first removing statistical outliers and cases with a LOS of 7 days or less. Next, we adjusted the number of cases remaining in each MS-LTC-DRG for the effect of SSO cases under §412.529. The short-stay adjusted discharges and corresponding charges were used to calculate "relative adjusted weights" in each MS-LTC-DRG using the HSRV method. In determining the FY 2008 MS-LTC-DRG relative weights, we also made adjustments, as necessary, to adjust for nonmonotonicity for the severity levels within a specific base MS-LTC-DRG. (Refer to the FY 2008 IPPS final rule with comment period for further information on the treatment of severity levels and adjustments for nonmonotonically increasing relative

weights for FY 2008 (72 FR 47282 through 47283 and 47293 through 47295).) Furthermore, we determined FY 2008 MS-LTC-DRG relative weights for the 185 MS-LTC-DRGs for which there were no LTCH cases in the database (that is, LTCH claims from the FY 2006 LTCH MedPAR files). (A list of the FY 2008 "no-volume" MS-LTC-DRGs and further explanation of their FY 2008 relative weight assignment can be found in the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47293).)

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

In the RY 2008 LTCH PPS final rule (72 FR 26882), under the broad authority conferred upon the Secretary under section 123 of Pub. L. 106-113 as amended by section 307(b) of Pub. L. 106-554 to develop the LTCH PPS, we established that beginning with the update for FY 2008, the annual update to the MS-LTC-DRG classifications and relative weights will be done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS-LTC-DRG classification and relative weight changes.

Historically, we had not updated the LTC-DRGs in a budget neutral manner because we believed that past fluctuations in the relative weights were primarily due to changes in LTCH coding practices rather than changes in patient severity. In light of the most recently available LTCH claims data at that time, which indicated that LTCH claims data no longer appeared to significantly reflect changes in LTCH coding practices in response to the implementation of the LTCH PPS, we believed that, beginning with FY 2008, it is appropriate to update the MS-LTC-DRGs in a budget neutral manner (that is, so that estimated aggregate LTCH PPS payments will neither increase nor decrease). Accordingly, in that same final rule with comment period, we established under §412.517(b) that the annual update to the MS-LTC-DRG classifications and relative weights be done in a budget neutral manner. (As noted above in section III.A. of this preamble, we revised the regulations at §412.503 to specify that "MS-LTC-DRG" is used in place of "LTC-DRG" for discharges occurring on or after October 1, 2007.) Consistent with that provision, we updated the MS-LTC-DRG classifications and relative weights for FY 2008 based on the most recent available data and included a budget neutrality adjustment. For further details on the methodology and calculation of the FY 2008 MS-LTC-DRG budget neutrality factor, refer to the FY 2008 IPPS final rule with comment period (72 FR 47295 through 47296).

Table 11 of the Addendum to the FY 2008 IPPS final rule with comment period lists the MS-LTC-DRGs and their respective transition blended budget neutral relative weights, geometric mean LOS, "short-stay outlier threshold" (that is, five-sixths of the geometric mean LOS), and the "IPPS Comparable Threshold" (that is, the IPPS geometric average length of stay plus one standard deviation) for each MS-LTC-DRG for

FY 2008 (see (72 FR 48143 through 48157), and the technical correction made in the October 10, 2007 correction notice (72 FR 57733), which has been reprinted in Table 3 of the Addendum of this final rule for convenience).

As we noted previously in this section, there were no new ICD-9-CM code requests for an April 1, 2008 update. Therefore, Version 25.0 of the MS-DRG GROUPER software established in the FY 2008 IPPS final rule with comment period will continue to be effective until October 1, 2008. Moreover, the MS-LTC-DRGs and relative weights for FY 2008 established in Table 11 of that same IPPS final rule with comment period (78 FR 48143 through 48157) will continue to be effective until October 1, 2008, (just as they would have been even if there had been any new ICD-9-CM code requests for an April 1, 2008 update). We note that Table 11 was corrected in the FY 2008 IPPS correction notice that appeared in the October 10, 2007 **Federal Register** (72 FR 57733) and is hereinafter referred to as the second FY 2008 IPPS correction notice. Accordingly, Table 3 in the Addendum of this final rule lists the MS-LTC-DRGs and their respective relative weights, geometric ALOS and "Short-Stay Outlier Threshold" that we will continue to use for the period of July 1, 2008 through September 30, 2009. (As noted above, this table is the same as Table 11 of the Addendum to the FY 2008 IPPS final rule with comment period, including the technical correction made in the second FY 2008 IPPS correction notice (72 FR 57733), which has been reprinted in Table 3 of the Addendum of this final rule for the reader's convenience.)

The next proposed update to the ICD-9-CM coding system was presented in the FY 2009 IPPS proposed rule (and there were no April 1, 2008 updates to the ICD-9-CM coding system). In addition, the proposed MS-DRGs and GROUPER for FY 2009 that

would be used for the IPPS and the LTCH PPS, effective October 1, 2008, and the proposed update to the MS-LTC-DRG relative weights for FY 2009 were presented in the recently published IPPS FY 2009 proposed rule (see 73 FR 23590 through 23608). The proposed MS-LTC-DRGs and their respective proposed relative weights, geometric ALOS and "Short-Stay Outlier Threshold" that that would be effective October 1, 2008 through September 30, 2009 are presented in Table 11 to the Addendum of the FY 2009 IPPS proposed rule (73 FR 23891 through 23905).

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

A. Overview of the Development of the Payment Rates

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

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth at §412.515 through §412.536. In this section, we discuss the factors that would be used to update the LTCH PPS standard Federal rate for the 2009 LTCH PPS rate year that would be effective for LTCH discharges occurring on or after July 1, 2008 through September 30, 2009. When we implemented the LTCH PPS in the

August 30, 2002 LTCH PPS final rule (67 FR 56029 through 56031), we computed the LTCH PPS standard Federal payment rate for FY 2003 by updating the latest available (FY 1998 or FY 1999) Medicare inpatient operating and capital cost data, using the excluded hospital market basket.

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

Furthermore, as specified at §412.523(d)(1), the initial standard Federal rate was reduced by an adjustment factor to account for the estimated proportion of outlier payments under the LTCH PPS to total estimated LTCH PPS payments (8 percent). For further details on the development of the FY 2003 standard Federal rate, see the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), and for subsequent updates to the LTCH PPS Federal rate, refer to the following final rules: RY 2004 LTCH PPS final rule (68 FR 34134 through 34140), RY 2005 LTCH PPS final rule (69 FR 25682 through 25684), RY 2006 LTCH PPS final rule (70 FR 24179 through

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

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

In the August 30, 2002 final rule implementing the LTCH PPS, we established a schedule at §412.535 for publishing information pertaining to the LTCH PPS. That schedule set a publication date of "on or before August 1 prior to the beginning of each Federal Fiscal Year (FFY)," which coincided with the statutorily mandated publication schedule for the IPPS (67 FR 55954). In the June 6, 2003 LTCH PPS final rule, we revised this schedule in §412.535 to provide that

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

At the time, we explained that the LTC-DRG patient classifications used by the LTCH PPS for FY 2003 are based directly on the same version of DRGs used by the IPPS, that is, Grouper 20 (68 FR 34126). As discussed above in section III of this final rule, effective for LTCH PPS discharges occurring on or after October 1, 2007, all references to LTC-DRGs and DRGs in the existing regulations are understood to represent MS-LTC-DRGs. This is addressed in the regulations at §412.503. Therefore, we did not make any changes to the timing for the annual update for LTC-DRG classifications and relative weights. The annual update to the DRG classifications and

relative weights continues to be published on a FFY cycle, as is the update of the acute care hospital IPPS DRG system. In changing the payment rate update schedule for the LTCH PPS, it was our intent to avoid concurrent publications of the annual updates for these two significant payment systems for purposes of administrative feasibility and efficiency. With this in mind, we changed the effective date for the annual update of the LTCH PPS payment rate from October 1 to July 1 of each year beginning with July 1, 2003. We believed this change would help use our limited resources effectively and facilitate a timely publication of both the IPPS and LTCH PPS proposed and final rules. Thus, currently the annual update of the LTCH PPS Federal rates does not coincide with the start of the FFY, but rather, are effective prior to the Federal FY.

In the RY 2009 LTCH PPS proposed rule (73 FR 5351 through 5352), we proposed a change to the current schedule for the annual updates of the LTCH PPS Federal payment rates to consolidate the rulemaking cycle for the annual update of the LTCH PPS. Under our proposed policy, the annual update to the LTCH PPS Federal payment rates along with the description of the methodology and data used to calculate these payment rates, and the annual updating of the MS-LTC-DRG classifications and associated weighting factors for LTCHs would occur on the same schedule and appear in the same publication. Therefore, under our proposed policy, the updates to the rates and the weights would both be effective on October 1 (on a Federal fiscal year schedule). Consequently, under this proposal the annual updates to the LTCH PPS Federal rates would no longer be published with a July 1 effective date.

We received several comments on our proposal to consolidate the annual payment rate and MS-LTC-DRG update schedules of the LTCH PPS to an October 1 through September 30 cycle, which are summarized below.

Comment: A large number of commenters, including MedPAC, agree with and strongly support our proposal to consolidate the LTCH rulemaking cycle to a single, annual rulemaking that corresponds with the IPPS annual update effective October 1 each year. In addition, many of these same commenters endorsed our proposal to extend the 2009 rate year by 3 months, allowing for a 15-month rate period (July 1, 2008 through September 30, 2009), rather than having a 3-month period followed by a 12-month rate year to transition from a July 1 to an October 1 update cycle. Commenters considered this proposal to be a reasonable one, and that a 15-month rate year would create an appropriate transition to an October 1 update by allowing for stability in the LTCH PPS payment rates. Commenters noted that a 3-month rate year followed by a 12-month rate year would be unduly burdensome. We received no comments in opposition to our proposal to consolidate the LTCH rulemaking cycles. However, we received many comments on our proposed update to the Federal rate for the 15-month RY 2009. One commenter suggested that CMS should include an inflationary update to address the 3 additional months.

Although supportive of the proposal to consolidate the LTCH rulemaking cycles to be effective October 1, two commenters expressed concern that CMS had not provided a description of how this combined rulemaking would be accomplished. Other commenters believe that there could be confusion between LTCH PPS payment policy changes and IPPS payment policy changes if the annual rulemaking for the LTCH PPS

were to be combined with the annual IPPS rulemaking. Consequently, these commenters recommended that the LTCH PPS rule be issued either separately from the IPPS rule or as a separate component within the IPPS rule to allow for easier accessibility and the ability to more accurately assess policy impacts on the LTCH PPS.

Response: We appreciate the positive responses to our proposal to consolidate the annual July 1 update for payment rates and the October 1 update for MS-LTC-DRG weights to a single annual update effective October 1, as well as the positive responses with regard to our proposal to extend the 2009 rate year for another 3 months; that is, from July 1, 2008 to September 30, 2009. We are finalizing these provisions in this final rule.

In response to several commenters' concerns that we had not provided sufficient details concerning the consolidation; that is, the manner in which we actually plan to produce the documents for the annual rulemaking for the LTCH PPS relative to the annual IPPS rulemaking, we are continuing to evaluate the commenters' suggestions concerning whether the LTCH PPS proposed and final rules should be included as part of the proposed and final IPPS publications or whether it would be more appropriate for there to be two separate publications—one for the proposed and final IPPS rules and the other for the proposed and final LTCH PPS rules. Any decision that we make must take into consideration many factors, including administrative feasibility and budgetary impact, that would affect the development and production of the annual rulemaking for the LTCH PPS and the IPPS. We do want to emphasize, however, that if the decision is made to produce the LTCH PPS rulemaking and the IPPS rulemaking in the same "package," we would make every effort to clearly identify the LTCH PPS sections and

differentiate those from the sections that only deal with the IPPS to avoid any confusion between LTCH PPS payment policy changes and IPPS payment policy changes. (We note that each of our regulations includes a title and a summary of its contents so the public can easily identify the material that applicable to LTCHs, including any material in a combined IPPS/LTCH PPS package. We also note that presently we publish the annual update to the MS-LTC-DRG classifications and relative weights as well as other payment policy changes to excluded IPPS hospitals (such as HwHs) in the IPPS proposed and final rules with no discernible confusion on the part of the public. Therefore, we believe the public would be able to easily recognize those portions of a combined package that pertain to the LTCH PPS.

In response to the commenter who suggested that we include an inflationary update to address the 3 additional months for purposes of the consolidation, we would note that this issue is discussed in the summary of the comments and responses on the proposed 15-month RY 2009 market basket estimate in section IV.C. of the preamble of this final rule. The summary of the comments and responses on our proposed update to the Federal rate for the 15-month RY 2009 can be found in section IV.E.2. of this preamble.

After reviewing the public comments, we are finalizing our proposal to change the current schedule for the annual updates of the LTCH PPS Federal payment rates in this final rule. We are consolidating the rulemaking cycle for the annual update of the LTCH PPS Federal payment rates and description of the methodology and data used to calculate these payment rates, with the annual updating of the MS-LTC-DRG classifications and associated weighting factors for LTCHs so that the updates to the rates

and the weights would both be effective on October 1 each Federal fiscal year. Under this change, the annual updates to the LTCH PPS Federal rates would no longer be published with a July 1 effective date.

We believe that it is important to note that our revision to the existing rulemaking cycle is a result of comments on prior rules, as well as recent input from the LTCH industry, as well as consideration of our resources. After further consideration of those comments and concerns, we agree that having the effective date of the annual update of the LTCH PPS Federal payment rates on July 1 of each year while retaining the October 1 effective date for updating LTC-DRG classifications and weights has proved both burdensome and time-consuming for all parties involved. We are aware that a consolidated update that we are finalizing will be resource intensive, but it will eliminate some duplicative resource use. For example, some of our resources used for the payment simulations that are used to estimate LTCH PPS payments for purposes of the respective impact analyses are duplicated for the annual LTCH PPS rate update and the annual MS-LTC-DRG update. Furthermore, the data used for LTCH PPS payment rate update impact analysis are also used in the annual MS-LTC-DRG. This consolidation of the rulemaking cycle will allow us to use the same information simultaneously for both these analyses. Moreover, we understand the concern that there are increased costs involved in updating the billing systems of LTCHs to accommodate two separate updates, one for the Federal rate and one for the DRG weights, in the same cost reporting period. We also considered the possibility that two separate updates could increase the potential for calculating payment errors under the LTCH PPS.

In order to revise the payment rate update to an October 1 through September 30 period, as proposed, we will extend the 2009 rate period to September 30, 2009 such that RY 2009 will be 15 months. This 15-month rate period will extend from July 1, 2008 through September 30, 2009. We believe that the additional 3 months to RY 2009 (July, August, and September) will provide for a smooth transition to a consolidated annual update for both the LTCH PPS payment rates and the LTCH PPS MS-LTC-DRG classifications and weighting factors. (When we developed this proposed policy, we considered the alternative of revising the payment rate update to an October 1 through September 30 period by shortening RY 2009 such that it would only be 3 months (that is, July 1, 2008 through September 30, 2008). We decided that this option would prove to be both burdensome and time consuming resulting in two payment rate changes within a very short (3 month) period of time.)

After the 2009 rate period, the rate period for the LTCH PPS payment rate and other policy changes will be October 1 through September 30, and the annual update to the MS-LTC-DRG classifications and relative weights will continue to be effective on October 1. The October through September rate period will first begin on October 1, 2009, therefore, the next update to the LTCH PPS Federal rates after the 15-month RY 2009 will be for RY 2010. We note that, once the annual LTCH PPS rate update cycle moves to October 1 effective October 1, 2009, the LTCH PPS rate year will coincide with Federal FY beginning in 2010.

In this final rule, we are finalizing our proposed revisions to §412.503 to redefine the LTCH PPS' rate year to mean October 1 through September 30, rather than from July 1 through June 30. We are also revising §412.535 to reflect the change to the annual

payment rate update cycle described above. The discussion of the 15-month market basket update for the 2009 rate year can be found below in sections IV.C.2.of this final rule.

C. LTCH PPS Market Basket

1. Overview of the Rehabilitation, Psychiatric and Long –Term Care (RPL) Market Basket

Historically, the Medicare program has used a market basket to account for price increases in the services furnished by providers. The market basket used for the LTCH PPS includes both operating and capital-related costs of LTCHs because the LTCH PPS uses a single payment rate for both operating and capital-related costs. The development of the initial LTCH PPS standard Federal rate for FY 2003, using the excluded hospital with capital market basket, is discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56033).

In the August 30, 2002 final rule (67 FR 56016 through 56017 and 56030), which implemented the LTCH PPS, we established the use of the excluded hospital with capital market basket as the LTCH PPS market basket. The excluded hospital with capital market basket was also used to update the limits on LTCHs' operating costs for inflation under the TEFRA reasonable cost-based payment system. We explained that we believe the use of the excluded hospital with capital market basket to update LTCHs' costs for inflation was appropriate because the excluded hospital market basket (with a capital component) measures price increases of the services furnished by excluded hospitals, including LTCHs. For further details on the development of the excluded hospital with

capital market basket, see the RY 2004 LTCH PPS final rule (68 FR 34134 through 34137).

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

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

basket based on the data of IRFs, IPFs and LTCHs is appropriate to use under the LTCH PPS since it is the best available data that reflects the cost structures of LTCHs.

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

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

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

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

In the RY 2009 proposed rule (73 FR 5352), based on Global Insight's 4th quarter 2007 forecast with history through the 3rd quarter of 2007, we proposed a 15-month market basket estimate of 3.5 percent for the proposed 15-month 2009 LTCH PPS rate year. In that same proposed rule, we also proposed that if more recent data were available, we would use it to determine the RY 2009 market basket update in the final rule. Consistent with our historical practice to use the most recent estimate of the RPL market basket available for the final rule, the most recent estimate of the RPL market basket for July 1, 2008 through September 30, 2009, based on Global Insight's 1st quarter 2008 forecast with history through the 4th quarter of 2007, is 3.6 percent. As we proposed and as noted above, we determine this 15-month market basket update by calculating the 5-quarter moving average index level for July 1, 2008 through September 30, 2009 and the 4-quarter moving average index level for July 1, 2007 through June 30, 2008. The percent change in these two values represents the 15-month market basket update for RY 2009. We note that, based on the most recent available data, if we were not consolidating the two annual LTCH PPS payment system updates by extending the 2009 LTCH PPS rate year by 3 months, the market basket estimate for a 12-month RY 2009 is 3.2 percent, based on the most recent estimate of the 12-month RPL market basket for July 1, 2008 through June 30, 2009. We determined this 12-month market basket estimate based on the method stated in the proposed rule (see 73 FR 5353).

Comment: We received one comment on the 15-month market basket estimate for RY 2009 that we presented in the proposed rule, which suggested that the proposed market basket update for RY 2009 does not include an inflationary update factor to

address the additional three months that would result from the proposal to extend the 2009 rate year through September 30, 2009.

Response: We disagree with the comment that the proposed market basket update of 3.5 percent does not reflect the entire 15-month period. The proposed RY 2009 3.5 percent market basket estimate as well as the RY 2009 3.6 percent market basket estimate we are establishing in this final rule as based on the forecasted increase in the LTCH PPS market basket (that is, the RPL market basket) to account for projected inflation for the entire 15-month RY 2009, which includes the additional 3 months that results from extending RY 2009 to move the annual rate update period from July 1 to October 1. As discussed in the proposed rule (73 FR 5352) and as reiterated above, we determined the 15-month market basket by calculating two average index levels: (1) the 5-quarter moving average index level for July 1, 2008 through September 30, 2009; and (2) the 4-quarter moving average index level for July 1, 2007 through June 30, 2008. The percent change in these two values represents the 15-month market basket estimate. By including the 3-month period of July 1, 2009 through September 30, 2009 in the first average index level calculated, we are capturing inflationary pressures for these three months. In comparison, if we were calculating only a 12-month market basket estimate for the period July 1, 2008 through June 30, 2009, we instead would calculate the 4-quarter moving average index level for July 1, 2008 through June 30, 2009 and the 4-quarter moving average index level for July 1, 2007 through June 30, 2008. The percent change in these two values represents the 12-month market basket estimate. Therefore, after our review of the public comments, we are finalizing the 15-month RPL market basket update of 3.6 percent for RY 2009, based on Global Insight's 1st quarter 2008

forecast. The update to the standard Federal rate for RY 2009 is discussed below in section IV.E. of this preamble.

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

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56027), consistent with the statutory requirement for budget neutrality in section 123(a)(1) of the BBRA, we estimated aggregate payments under the LTCH PPS for FY 2003 to be equal to the estimated aggregate payments that would be made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations used the best available data at the time and necessarily reflected several assumptions including costs, inflation factors and intensity of services provided. In conducting our budget neutrality calculations, we took into account the statutory requirement that certain statutory provisions that affect the level of payments to LTCHs in years prior to the implementation of the LTCH PPS shall not be taken into account in the development and implementation of the LTCH PPS. Specifically, section 307(a)(2) of the BIPA requires that the increases to the target amounts and the increases to the cap on the target amounts for LTCHs provided for by section 307(a)(1) of the BIPA (as set forth in section 1886(b)(3)(J) of the Act) and the enhanced bonus payments for LTCHs provided for by section 122 of the BBRA (as set forth in section 1886(b)(2)(E) of the Act) are not to be taken into account in the development and implementation of the LTCH PPS.

We have been monitoring payment data in order to evaluate whether there is a significant difference between the payments estimated on the basis of the data available at the time of the August 30, 2002 LTCH PPS final rule(67 FR 56027 through 56037)

and payment estimates based on more complete data that have become available since that time. We indicated from the inception of the LTCH PPS that it was possible for the aggregate amount of actual payments in FY 2003 to be significantly higher or lower than the estimates on which the budget neutrality calculations were based to the extent that later, more complete data differ significantly from the data that were available at the time of the original calculations.

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

In the RY 2009 LTCH PPS proposed rule (72 FR 5353), based on the best available data at that time, we estimated that total Medicare program payments for LTCH services over the next 5 LTCH PPS rate years would be $4.67 billion for the 2009 LTCH PPS rate year; $4.82 billion for the 2010 LTCH PPS rate year; $5.06 billion for the 2011 LTCH PPS rate year; $5.36 billion for the 2012 LTCH PPS rate year; and $5.73 billion for the 2013 LTCH PPS rate year.

In this final rule, consistent with the methodology established in the August 30, 2002 final rule (67 FR 56036), and based on the most recent available data, for the readers benefit, we are providing an estimate of total Medicare program payments

for LTCH services for the next 5 LTCH PPS rate years in Table I. These estimates take into account the effects of changes as a result of the recent Medicare, Medicaid, and SCHIP Extension Act of 2007.

TABLE I:

LTCH PPS Rate Year	Estimated Payments ($ in billions)
2009	4.78
2010	4.99
2011	5.14
2012	5.36
2013	5.67

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), these estimates are based on the most recent available data. These estimates are also based on our estimate of LTCH PPS rate year payments to LTCHs using CMS' Office of the Actuary's (OACT) most recent estimate of the RPL market basket, which is based on information from Global Insight, Inc., of 3.2 percent for the 2009 LTCH PPS rate year, 2.9 percent for the 2010 LTCH PPS rate year, 3.0 percent for the 2011 LTCH PPS rate year, and 3.2 percent for the 2012 and 2013 LTCH PPS rate years. We note that while the provisions in the MMSEA are current law and OACT develops its spending projections based on existing policy, changes that are being adopted in this final rule, are not considered to be existing policy and therefore, are not shown in Table I. We also considered OACT's most recent projections of changes in Medicare beneficiary enrollment of -0.3 percent in the 2009 LTCH PPS rate year, 0.2 percent in the 2010 LTCH PPS rate year, 0.5 percent in the 2011 LTCH PPS rate year, 1.5 percent in the 2012 LTCH PPS rate year and, 2.5 percent in the 2013 LTCH PPS rate year. It is important to note that, while we provide these estimates of future payments

under the LTCH PPS in order to provide the public with a projected estimate of payments to LTCHs, these estimates will be neither the basis for determining whether the one-time budget neutrality adjustment available under §412.523(d)(3) of the regulations should be proposed, nor are these estimates the basis for any of the policy changes adopted in this final rule. It is also important to note that any proposal regarding the one-time budget neutrality adjustment would be based solely on the data that would be available at the time of the proposal, rather than on projections of payments under LTCH PPS for future years.

In the August 30, 2002 LTCH PPS final rule implementing the LTCH PPS (67 FR 55954), we set forth the implementing regulations, based upon the broad authority granted to the Secretary, under section 123 of the BBRA (as amended by section 307(b) of the BIPA). Section 123(a)(1) of the BBRA required that the system "maintain budget neutrality." The statute requires the LTCH PPS to be budget neutral in FY 2003, so that estimated aggregate payments under the LTCH PPS for FY 2003 should be equal to the estimated aggregate payments that would be made if the LTCH PPS were not implemented for FY 2003. The methodology for determining the LTCH PPS standard Federal rate for FY 2003 that would "maintain budget neutrality" is described in considerable detail in the August 30, 2002 final rule (67 FR 56027 through 56037). As we discussed previously in this section, our methodology for estimating payments for the purposes of budget neutrality calculations used the best available data, and necessarily reflected assumptions in estimating aggregate payments that would be made if the LTCH PPS was not implemented. In the August 30, 2002 final rule, we also stated our intention to monitor LTCH PPS payment data to evaluate whether later data varied significantly

from the data available at the time of the original budget neutrality calculations (for example, data related to inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). To the extent the later data significantly differ from the data employed in the original calculations, the aggregate amount of payments during FY 2003 based on later data may be higher or lower than the estimates upon which the budget neutrality calculations were based. In that same final rule, the Secretary exercised his broad authority in establishing the LTCH PPS and provided for the possibility of a one-time prospective adjustment to the LTCH PPS rates by October 1, 2006, in §412.523(d)(3). This deadline was revised to July 1, 2008, in the RY 2007 LTCH PPS final rule. As we discussed in the RY 2007 LTCH PPS final rule (71 FR 27842 through 27844), because the LTCH PPS was only recently implemented, sufficient new data had not yet been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, in that same final rule, we did not implement the one-time adjustment provided under §412.523(d)(3) so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the PPS rates for future years. However, we stated that we would continue to collect and interpret new data as it became available in order to determine whether we should propose such an adjustment in the future. Therefore, we revised §412.523(d)(3) by changing the original October 1, 2006 deadline (established in the August 30, 2002 final rule that implemented the LTCH PPS) to July 1, 2008, to postpone the possible one-time adjustment due to the time lag in the availability of Medicare data upon which a proposed adjustment would be based. We noted that there is a lag time between the submission of

claims data and cost report data, and the availability of that data in the MedPAR files and HCRIS, respectively. As also explained in that same final rule, we believed that postponing the deadline of the possible one-time prospective adjustment to the LTCH PPS rates provided for in §412.523(d)(3) to July 1, 2008, would allow our decisions regarding a possible adjustment to be based on more complete and up-to-date data. It should be noted that, in the years following the initial implementation of the LTCH PPS, we have already adopted some revised policies and adjustments to LTCH PPS payment levels. However, none of these revised policies and payment adjustments have addressed the intended purpose of the adjustment allowed under §412.523(d)(3) of the regulations, to ensure that any significant difference between the original estimates and calculations based on more recent data are not perpetuated in the LTCH PPS rates for future years. For example, the adjustments that we have made to account for coding changes in excess of real severity increases in RY 2007 and RY 2008 were made to account for changes in coding behavior in the years following the implementation of the LTCH PPS, and not to address any issue regarding the budget neutrality calculations that were used to establish the base rate for the LTCH PPS.

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

Comment: Several commenters supported the proposed change in §412.523(d)(3) of regulations to conform with the requirements of section 114(c)(4) of MMSEA, delaying the effective date of any one-time budget neutrality adjustment until no earlier than December 29, 2010. A few commenter disagreed with the proposed change to §412.523(d)(3) because it did not include a specific date after which time CMS would no longer be able to implement a one-time budget neutrality as is currently specified in the regulations (that is, July 1, 2008). These commenters believe that the lack of an "end date" in the proposed change to §412.523(d)(3) leaves LTCHs in a perpetual state of uncertainty, and therefore, recommend that CMS should specify in the regulations a reasonable date beyond which this adjustment can be made.

Response: We appreciate the commenters support of the proposed change in §412.523(d)(3) to conform with the requirements of section 114(c)(4) of MMSEA, delaying the effective date of any one-time budget neutrality adjustment until no earlier than December 29, 2010. We understand commenters' concerns and agree that it is reasonable to include a date by which the one-time budget neutrality adjustment must be implemented in order to provide predictability in LTCH PPS payments. In taking into account the statutory requirement that any one-time budget neutrality adjustment can be effective no earlier than December 29, 2010, and that annual updates to the LTCH PPS will be effective October 1 each year (beginning October 1, 2009, as discussed above in section IV.B. of this preamble), we believe that October 1, 2012 would allow us sufficient time after the statutorily required 3-year delay to develop, propose and finalize any one-time budget neutrality adjustment. Therefore, we are revising the regulations at §412.523(d)(3) to delay the effective date of any one-time budget neutrality adjustment

so that any such adjustment would be made no earlier than December 29, 2010, and no later than October 1, 2012. We believe that this date will allow adequate time to consider any additional comments that may arise after the MMSEA 3-year delay concerning the potential methodology we presented in the RY 2009 proposed rule without postponing indefinitely into the future any proposal for making an adjustment.

Prior to the enactment of the MMSEA, we had developed a methodology for evaluating whether to propose a one-time budget neutrality adjustment under §412.523(d)(3) of the regulations. In order to inform the public of our thinking, and to stimulate comments for our consideration during the 3-year delay in implementing any one-time budget neutrality adjustment under the law referenced above, we discussed our analysis and its results in the proposed rule (73 FR 5356 through 5360). Evaluating the appropriateness of a possible future proposal for a one-time prospective adjustment under §412.523(d)(3) required a thorough review of the relevant LTCH data, as we discussed in the proposed rule. When we established the FY 2003 standard Federal rate in a budget neutral manner, we used the most recent LTCH cost data available at that time (that is, FY 1999 data), and trended that data forward to estimate what Medicare would have paid to LTCHs in FY 2003 under the TEFRA payment system if the PPS were not implemented for FY 2003 (67 FR 56033). We subsequently conducted a thorough review of the most recent relevant data and discussed those findings in the RY 2009 proposed rule. At the time we drafted the proposed rule, cost data from FY 2002, representing the final year LTCHs were paid under the TEFRA payment system, had become available. The cost report data for FY 2002 is comprised of a high proportion of settled and audited cost reports submitted by LTCHs. We also have acquired payment

data on the first year of the LTCH PPS (that is, FY 2003). On the basis of our review of these data sources, we developed a potential methodology for determining whether the one-time adjustment available under §412.523(d)(3) of the regulations should be proposed. On the basis of this methodology, we also presented a potential method for computing an adjustment, if appropriate. Employing that methodology, our analysis indicated that a permanent budget neutrality adjustment factor of 0.9625 to the LTCH PPS standard Federal rate could be warranted. Consistent with the requirements of section 114(c)(4) of the recently enacted MMSEA, we did not propose any adjustment for the upcoming rate year. However, we invited public comment on the analysis which we presented in the proposed rule. We noted that we would consider these comments if and when we decide to propose an actual adjustment. We also noted that in the final rule, we would respond to any comments on the proposed changes to §412.523(d)(3) of the regulations that would: (1) specify the methodology for the one-time budget neutrality adjustment; and (2) implement the requirements of section 114(c)(4) of Pub. L. 110-173, in the final rule.

In order to determine whether a one-time budget neutrality adjustment could be warranted, it is necessary to estimate both aggregate payments under the LTCH PPS for FY 2003 and the estimated aggregate payments that would have been made under the TEFRA system in FY 2003 if the LTCH PPS were not implemented. While we know actual TEFRA payments to LTCHs for FY 2002, the last year of payment under that methodology, it is necessary to estimate what TEFRA payments would have been in FY 2003 if the new LTCH PPS had not been implemented. In developing the methodology for evaluating a one-time adjustment that we presented in the proposed rule, we

considered whether we should employ actual FY 2003 costs to calculate estimated TEFRA payments for FY 2003 or employ costs for FY 2002 trended forward to FY 2003 as the basis for the calculation. We noted that basing the estimate on actual FY 2003 costs would avoid the need to employ any factor to update costs from FY 2002 to FY 2003. However, since FY 2003 was the first year of payment under the LTCH PPS, the cost experience of LTCHs in that year would reflect their response to the incentives provided by the new payment system, instead of reflecting behavior under the reasonable cost payment system. Indeed, implementation of an LTCH PPS should directly affect the behavior of LTCHs, and therefore, the level of costs in LTCHs. One of the incentives of a PPS is to improve efficiency in the delivery of care, which generally results in decreased cost per discharge. For this reason, employing FY 2003 costs directly could be a poor basis for estimating payments that "would have been made if the LTCH PPS were not implemented." We indicated in the proposed rule that trending forward for 1 year the costs incurred under the last year of the TEFRA payment system poses a smaller prospect for distortion than using costs incurred during the subsequent year, when the incentives faced by LTCHs to reduce costs could have had a significant effect. Therefore, we indicated that we believed it may be preferable to base our calculation of the estimated aggregate payments that would have been made if the LTCH PPS were not implemented (that is, estimated FY 2003 TEFRA payments) on FY 2002 costs, trended forward to FY 2003 using the excluded hospital with capital market basket. And we noted in this context that some representatives of LTCHs had expressed concern that employing FY 2003 costs directly would provide a poor basis upon which to estimate payments that "would have been made if the LTCH PPS were not implemented" for precisely the

reasons we have just discussed. We also noted that basing the estimate of FY 2003 TEFRA payments on FY 2002 costs trended forward should satisfy these concerns.

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

methodology in FY 2003 for those same FY 2002 discharges. In other words, we believe that the best approach would be to compare--

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

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

Therefore, in the absence of the MMSEA, we stated in the proposed rule that we would have proposed to employ the general methodology we have just described to determine: (1) whether the one-time adjustment available under §412.523(d)(3) of the regulations should be proposed for RY 2009, and (2) if such adjustment should be proposed, the actual proposed adjustment factor. In the proposed rule, we did propose to revise the current language of §412.523(d)(3) of the regulations to conform more accurately reflect the purpose of providing for a possible one-time budget neutrality adjustment. At the time of the final LTCH PPS rule in 2002, we described the nature of the one-time adjustment in very general terms. Specifically, that section currently provides the following:

> The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates on or before July 1, 2008 so that the effect of any significant difference between actual payments and estimated payments for

the first year of the long term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years.

As we stated in the proposed rule, our policy objective in providing for this one-time budget neutrality adjustment has always been to ensure that computations based on the earlier, necessarily limited (but at that time best available) data available at the inception of the LTCH PPS would not be built permanently into the rates if data available at a later date could provide more accurate results. Prior to the thorough analysis we conducted in preparation for the RY 2009 proposed rule, we had believed that the appropriate method for meeting this policy objective involved comparing actual payment data from the first year of payment under the LTCH PPS to our earlier estimate of payments in the first year of the LTCH PPS. As we have just discussed, we determined that the most appropriate methodology for evaluating an adjustment to the original budget neutrality adjustment did not involve comparing the payments estimated in the original calculations against the "actual payments… for the first year," strictly speaking. Rather, as we discussed in the proposed rule, we believe that it is more appropriate to compare payments in the first year under the LTCH PPS to what payments would have been under the prior TEFRA rules for that year based on the best available data. As a result, under the broad authority of section 123 of the BBRA, as amended by section 307(b) of BIPA, to make appropriate adjustments to the LTCH PPS, we proposed to revise §412.523(d)(3) of the regulations. Furthermore, as discussed in the proposed rule, considerations of consistency and other factors suggest that the most appropriate comparison would employ an estimate of FY 2003 LTCH PPS payments based on discharges from FY 2002. The cost incurred by LTCHs for those discharges would also be the basis for the best estimate of what would have been paid in FY 2003 under the TEFRA system. As we

have discussed previously, we also proposed to revise that section of the regulations to correspond with the requirements of section 114(c)(4) of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Specifically, we proposed to revise §412.523(d)(3) of the regulations to read as follows:

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

Comment: One commenter objected to the proposed change in the regulation on the grounds that it does not truly reflect the methodology we discussed more clearly, especially since the proposed text of the regulation makes no mention of FY 2003, the first year of payments under the LTCH PPS. The commenter further objected that the phrases "data used in the original computations" and "more recent data to determine budget neutrality" in the proposed regulation text are imprecise.

Response: We do not agree that the phrases "data used in the original computations" and "more recent data to determine budget neutrality" in the proposed regulation text are imprecise. The meanings of these terms are fully explained in the detailed account presented in the preamble to the proposed rule (73 FR 5354 through 5360) of the methodology that we could employ in a proposal. We also clearly indicated in the preamble text that if we had proposed a one-time adjustment in the RY 2009 proposed rule, we would have used more recent data to estimate budget neutrality for the first year of the LTCH PPS, FY 2003. As we have also discussed, we indicated that we believe it is appropriate to use certain data elements from FY 2002, specifically FY 2002 TEFRA costs and FY 2002 LTCH discharges, as the most effective and consistent way to

estimate budget neutrality for FY 2003 while avoiding the potentially distorting effects of factors such as behavioral changes in the first year of the new payment system. However, we often avoid specifying precise data elements and other details of methodology in regulations text, and instead provide for the regulations to reflect in general but accurate terms the methodology to be employed. (Instead, we typically include a discussion of specific data elements and complex details of our methodology in the preamble where we can flesh out in greater detail the nuances of our policies.) The current regulations text is not consistent with the methodology we had developed as the best means to evaluate whether to propose an adjustment. Our proposed regulation text captured the concepts in general, but more accurate, terms. In response to this comment we are, however, revising the proposed regulation text to specify that the estimates of budget neutrality do indeed pertain to FY 2003, the first year of the LTCH PPS. As also discussed above, we are also revising the proposed regulations text to include a specific end date after which CMS would no longer consider implementing a one-time budget neutrality adjustment (that is, on or before October 1, 2012). In addition, the structure of the regulations text we are finalizing would work if we ultimately proposed to use FY 2002 data to estimate FY 2003 payments or if we would propose to use FY 2003 data. The final regulation text that we are adopting in this final rule will therefore read:

> The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates no earlier than December 29, 2010 and by no later than October 1, 2012, so that the effect of any significant difference between the data used in the original computations of budget neutrality for FY 2003 and more recent data to determine budget neutrality for FY 2003 is not perpetuated in the prospective payment rates for future years.

Comment: Two commenters alleged that we had failed to provide data supporting the proposal of making a one-time prospective adjustment to the LTCH rates no earlier than December 29, 2010. The commenters added that, without the ability to review the applicable data, the public cannot provide meaningful comment on this aspect of the proposed rule.

Response: We did not actually propose to make a one-time prospective adjustment to the LTCH rates under §412.523(d)(3) in the proposed rule. As noted above, in the proposed rule we presented a potential methodology for determining whether the one-time adjustment available under §412.523(d)(3), could be warranted if we presented our analysis based on employing that method, and invited public comment on that analysis indicating that we would take such comments into account "if and when we decide to propose an actual adjustment" (see 73 FR 5354 and 5360). We did, however, propose to revise the regulations to provide that such an adjustment will not be made prior to December 29, 2010, as required by the MMSEA. We also described the potential methodology that we had developed prior to the passage of the MMSEA and revised the regulations text to be more consistent with the purpose of a one-time budget neutrality adjustment.

We do not agree that the data we used in developing our estimate of a potential adjustment presented in the proposed rule has been unavailable to commenters. We clearly identified our data sources in the proposed rule, for example, cost report data from the Hospital Cost Reporting Information System for FYs 1999 through 2003, and FY 2002 LTCH MedPAR data (see 73 FR 5357 and 5359). We also described in great detail how we employed those data, including assumptions and adjustments that were

necessary in developing a reasonable estimate. These data are readily available through our standard data request procedures that can be obtained by communication with our Office of Information Services (OIS). Information about obtaining MedPAR files and other Medicare data files is posted on the CMS Web page at: http://www.cms.hhs.gov/FilesForOrderGenInfo/. Furthermore, we point out that other commenters were able to employ these and similar data sources to comment on the methodology that we discussed (in fact, one commenter commissioned an entire report on the "Assessment of the Proposed One-time Adjustment for Long Term Care Hospitals"). Therefore, we disagree that the public lack the necessary data to provide meaningful comment on that informational aspect of the proposed rule.

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

0.25 percentage point from actual input price changes (72 FR 47425). We do not believe that we should treat differences greater than or equal to 0.25 percent as not "significant," since the effect of any difference will be magnified as the rates are updated each year.

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

- Estimate each LTCH's payment per discharge for inpatient operating costs under the TEFRA system for FY 2003;

- Estimate each LTCH's payment per discharge for capital-related costs for FY 2003; and

- Sum each LTCH's estimated operating and capital payment per case to determine its estimated total FY 2003 TEFRA payment system payment per discharge.

In the proposed rule, we discussed each of these steps in detail (73 FR 5356-5359).

Once we have estimated total TEFRA payments as the sum of each LTCH's estimated operating and capital payment per case, it is also necessary to estimate FY 2003 payments under the LTCH PPS. We also discussed the method for making this estimate in the proposed rule (73 FR 5359 through 5360). As the discussion in the proposed rule indicated, our analysis suggests that an adjustment of 3.75 percent to the standard Federal rate may have been warranted. We expect to address the issue again when it is closer to the time section 114(c)(4) of the MMSEA permits us to implement a one-time adjustment under §412.523(d)(3). In the meantime, we received a number of comments on the methodology that we have described. We also received a number of comments addressing the merits of implementing any one-time budget neutrality adjustment. As we stated in the propose rule (73 FR 5360), we will take these comments into account prior to proceeding with any proposal for a one-time budget neutrality adjustment on or after December 29, 2010, and we will consider them at the time when we develop such a proposal.

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

1. Background

At §412.523(c)(3)(ii) of the regulations, for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate by a rate increase factor to adjust for the most recent estimate of the increases in prices of an appropriate market basket of goods and services for LTCHs. We established the policy of annually updating

the standard Federal rate because at that time we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after FY 2003. When we moved the date of the annual update of the LTCH PPS from October 1 to July 1 in the RY 2004 LTCH PPS final rule (68 FR 34138), we revised §412.523(c)(3) to specify that for LTCH PPS rate years beginning on or after July 1, 2003, the annual update to the standard Federal rate for the LTCH PPS would be equal to the previous rate year's Federal rate updated by the most recent estimate of increases in the appropriate market basket of goods and services included in covered inpatient LTCH services. At that time, we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after RY 2004.

In the RY 2007 LTCH PPS final rule (71 FR 27818), we explained that rather than solely using the most recent estimate of the LTCH PPS market basket as the basis of the update factor for the Federal rate for RY 2007, we believed that based on our ongoing monitoring activity, it was appropriate to adjust the Federal rate to account for the changes in coding practices (rather than patient severity). We established at §412.523(c)(3)(iii) of the regulations that the update to the standard Federal rate for the 2007 LTCH PPS rate year was zero percent. This was based on the most recent estimate of the LTCH PPS market basket at the time which was offset by an adjustment to account for changes in case-mix in prior periods due to changes in coding practices rather than increased patient severity in FY 2004. Therefore, effective from July 1, 2006 through June 30, 2007, the standard rate was $38,086.04 (71 FR 27818).

For the following year, we also considered changes in coding practices rather than patient severity in establishing the update to the Federal rate for the 2008 LTCH PPS rate

year. In the RY 2008 final rule (72 FR 26887 through 27890), we adjusted the Federal rate based on the most recent estimate of market basket (3.2 percent) and an adjustment to account for changes in coding practices (2.49 percent) in FY 2005. Accordingly, we established at §412.523(c)(3)(iv) that the update to the standard Federal rate for RY 2008 was 0.71 percent. Consequently, in the RY 2008 final rule, we established the LTCH PPS standard Federal rate, effective from July 1, 2007 through June 30, 2008, of $38,356.45 (see 72 FR 26890).

In the RY 2009 proposed rule, we mentioned that the newly enacted MMSEA contained a provision addressing the standard Federal rate for RY 2008 (73 FR 5360 through 5362). Specifically, section 114(e)(1) of Pub. L. 110-173 adds a new subsection 1886(m)(2) of the Act, which provides that the base rate for RY 2008 "shall be the same as the base rate for hospital discharges occurring during the rate year ending in 2007." In addition, section 114(e)(2) of Pub. L. 110-173 indicates that section 1886(m)(2) of the Act "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008" (that is, the first 9 months of RY 2008). We noted that the statute uses the term "base rate," which is an undefined term in both section 1886(m) of the Act and in 42 CFR Part 412, subpart O. As we explained in the LTCH PPS RY 2009 proposed rule (73 FR 5361), we are interpreting that term to be the standard Federal rate because we believe Congress meant to eliminate the 0.71 percent update from the RY 2008 standard Federal rate. Under this interpretation, the standard Federal rate for RY 2008 would be the same as the standard Federal rate for RY 2007, that is, the 0.71 percent update finalized in the RY 2008 LTCH PPS final rule would be reversed. Therefore, we believe that the term "base rate" used in section 114(e)(1) of MMSEA refers to the standard Federal rate. In

subsequent sections of this preamble, we are using the term standard Federal rate instead of "base rate" when referencing the provision in section 114(e)(1) of MMSEA in order to avoid further confusion.

Furthermore, we believe section 114(e) of the MMSEA specifically revises the standard Federal rate for RY 2008. Specifically, section 114(e)(1) of MMSEA provides that under the new section 1886(m)(2) to the Act, the standard Federal rate for RY 2008 shall be the same as the standard Federal rate for RY 2007. The standard Federal rate for RY 2007 was $38,086.04 (71 FR 27818). Section 114(e)(2) of MMSEA delays the application of the revised standard Federal rate of section 114(e)(1). Specifically, section 114(e)(2) of the MMSEA states that the revised standard Federal rate of section 114(e)(1) "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008." Therefore, under the above interpretation, we believe it is appropriate that LTCH payments for discharges occurring on or after July 1, 2007 through March 31, 2008, will continue to include an adjustment of 0.71 percent which was included in the standard Federal rate that was in effect when the MMSEA was enacted on December 29, 2007. Also, we believe it is appropriate for discharges occurring on or after April 1, 2008 through June 30, 2008, to be paid based on the revised RY 2008 standard Federal rate of $38,086.04, while payments for discharges occurring from July 1, 2007 through March 31, 2008 will be determined based on the rate that had been used prior to the enactment of the MMSEA ($38,356.45).

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

As discussed above, the MMSEA revises the standard Federal rate for RY 2008 to $38,086.04 (the same as the standard Federal rate for 2007) while specifying that this rate

"shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008" (that is, the first 9 months of RY 2008). In the proposed rule, consistent with our historical practice, we proposed to update the standard Federal rate from the previous year (that is, the standard Federal rate for RY 2008, which the MMSEA has revised to ($38,086.04) to determine the standard Federal rate for RY 2009. Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, we proposed an annual update to the standard Federal rate for the 15-month 2009 rate year based on the most recent LTCH PPS market basket estimate of 3.5 percent (based on the best available data at that time) and an adjustment of 0.9 percent to account for the increase in case-mix in a prior period (FY 2006) that resulted from changes in coding practices rather than an increase in patient severity.

As we discussed in greater detail in the RY 2007 and RY 2008 LTCH PPS final rules (71 FR 27819 through 27827 and 72 FR 26887 through 26890, respectively), while we continue to believe that an update to the LTCH PPS standard Federal rate should be based on the most recent estimate of the LTCH PPS market basket, we believe it is appropriate that the standard Federal rate be offset by an adjustment to account for any changes in coding practices that do not reflect increased patient severity. Such an adjustment protects the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients (71 FR 27819 through 27827).

We continue to believe that an update to the LTCH PPS standard Federal rate year should be based on the most recent estimate of the LTCH PPS market basket, and, if appropriate, an adjustment to account for changes in coding practices that do not reflect

increased patient severity. Furthermore, as we discussed in the RY 2009 proposed rule (73 FR 5362), we did not finalize the proposed case-mix budget neutrality factor for the adoption of the severity adjusted MS-LTC-DRG patient classification system to the FY 2008 MS-LTC-DRG relative weights in the FY 2008 IPPS final rule. Rather, we noted that consistent with past LTCH payment policy, we would continue to monitor LTCHs and we could propose to make adjustments when updating the standard Federal rate in the future, to account for improvements in coding and documentation that do not reflect any real changes in case mix during these years that we are implementing MS-LTC-DRGs

As we discussed in the RY 2009 proposed rule, in determining the proposed update to the standard Federal rate for the 2009 LTCH PPS rate year, we performed a case-mix index (CMI) analysis using the most recent available LTCH claims data (FY 2006 MedPAR files) and estimated the observed CMI change for FY 2006 to be 1.9 percent (based on the most recent available LTCH case-mix data from FY 2005 compared to FY 2006). As discussed in the RY 2009 proposed rule (73 FR 5362), we continue to believe it is appropriate to utilize the estimate of real CMI increase of 1.0 percent, based on the well-established RAND study referred to in the RY 2008 final rule, as the proxy for the portion of the observed 1.9 percent CMI increase from FY 2005 to FY 2006 that represents real CMI changes for use in determining the RY 2009 Federal rate update. Accordingly, we proposed that 0.9 percent (1.9 – 1.0 = 0.9) of the observed 1.9 percent CMI increase from FY 2005 to FY 2006 reflects CMI increase that is due to changes in coding practices rather than patient severity.

The following is a summary of the comments received and our responses.

Comment: A number of commenters disputed CMS' interpretation of the MMSEA provision in section 114(e)(1) which specifies that "for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007." That is, while CMS believes Congress intended to revise the standard Federal rate for RY 2008 to be the same as the standard Federal rate for RY 2007, a number of commenters asserted that the language in this provision indicates that the RY 2007 standard Federal rate is to be applied only to "discharges occurring during the rate year ending in 2008." Furthermore, the commenters believed section 114(e)(2) of the MMSEA limits the application of the "lower" rate specified in section 114(e)(1) such that this "lower" rate does not apply to "discharges occurring on or after July 1, 2007, and before April 1, 2008" thereby limiting the application of this "lower" rate to just 3-months of RY 2008. That is, the commenters stated that the language Congress used neither explicitly revises the RY 2008 standard Federal rate, nor does it otherwise specifically grant CMS the authority to update the RY 2009 standard Federal rate based on the rate specified in this provision of the MMSEA. One commenter stated: "There is no basis to assume that Congress seeks to reduce LTCH payments for years to come through Section 114(e)(2). The three-month freeze on the standard rate is a distinct act of Congress that should not be applied beyond the end of RY 2008." Several commenters characterized CMS' proposal to update the RY 2008 standard Federal rate based on the MMSEA revised rate of $38,086.04 as "arbitrary and capricious." The commenters also believed implementation of the proposed update on the lower rate of $38,086.04 would produce a "retroactive effect" and is tantamount to "retroactive rule making."

Commenters protested the proposed RY 2009 update on the grounds that since "CMS actually provided no increase in the Federal rate for RY 2007, and now proposes to ignore any update for RY 2008, the newly proposed 2.6 percent increase to the RY 2009 rate is actually an increase to the standard Federal rate that was in effect on July 1, 2006, a full two years prior to the beginning of RY 2009." Furthermore, the commenters urged CMS to apply the full market basket to a higher rate, that is, the RY 2008 standard Federal rate that had been finalized in the RY 2008 final rule ($38,356.45), rather than to the MMSEA revised RY 2008 standard Federal rate of $38,086.04.

Response: We disagree with the commenters that updating the RY 2008 standard Federal rate based on the MMSEA revised RY 2008 standard Federal rate of $38,086.04 is "arbitrary and capricious." For the reasons discussed in detail below, we continue to believe that our proposed (and final) approach for calculating the RY 2009 standard Federal rate is appropriate, and consistent with a plain reading of the statute, Congressional intent, and our historic methodology for calculating the standard Federal rate.

Section 114(e)(1) of MMSEA adds section 1886(m)(2) to the Act which specifies the standard federal rate for RY 2008. Specifically, section 1886(m)(2) provides that "for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007." Section 1886(m)(2) of the Act on its face explicitly provides for a single revised RY 2008 standard federal rate. With respect to section 114(e)(2) of MMSEA, this section provides that section 1886 (m)(2) of

the Act shall not apply to discharges occurring on or after July 1, 2007 and before April 1, 2008. When read in conjunction, we believe sections 1886(m)(2) of the Act and 114(e)(2) of MMSEA provide that the revised RY 2008 standard Federal rate (which is the same as the RY 2007 standard Federal rate) is the standard Federal rate for all of RY 2008, however, for payment purposes, discharges occurring on or after July 1, 2007, and before April 1, 2008 simply will not be paid based on that revised RY 2008 standard Federal rate.

In contrast to the commenters' belief that section 114(e)(2) limits the reduced standard Federal rate in section 1886(m)(2) to a 3-month period (that is, the part of RY 2008 not included in "on or after July 1, 2007, and before April 1, 2008"), this section actually provides that the standard Federal rate specified in section 1886(m)(2) "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008." To the extent the MMSEA directs the revised standard Federal rate in section 1886(m)(2) shall not apply during a specified period, it also necessarily means that the standard Federal rate in section 1886(m)(2) would otherwise apply for the entire RY 2008. We note that to the extent Congress intended to only revise the standard Federal rate for the last three months of RY 2008, it could have easily drafted § 1886(m)(2) to state this. Moreover, Congress could have amended the Act to provide for two separate standard Federal rates for RY 2008, just as it has similarly done in the past with updates. For example, in at least one other PPS (for example, home health), Congress split the updates during a single year and revised the statute in a manner to specifically provide for the split updates. Therefore, contrary to the commenters' assertion, we believe a plain reading of the statute indicates that Congress intended that the standard Federal rate for the long-

term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008 (that is, RY 2008) is the same as the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by zero percent (that is, the same as the standard Federal rate for RY 2007).

In addition, Congress is aware that we determine the standard Federal rate for a given year by taking the standard Federal rate from the previous year and updating it. Since Congress did not expressly direct us to deviate from that historical practice, the natural presumption is that we would take the revised RY 2008 standard Federal rate specified in § 1886(m)(2) and update it in order to calculate the RY 2009 standard Federal rate. Furthermore, since our proposed calculation of the RY 2009 standard Federal rate is consistent with our long-standing practice of calculating the standard Federal rate, we do not believe that our methodology for calculating the RY 2009 standard Federal rate is arbitrary or capricious. In response to the comment that the MMSEA did not specifically grant CMS the authority to update the RY 2009 standard Federal rate based on the revised RY 2008 standard Federal rate specified in the MMSEA, we note that such a grant was unnecessary. This is because Congress had already conferred broad discretionary authority to the Secretary under § 307 (b)(1) of Pub. L. 106-554 (also referenced under new 1886(m)(1) of the Act) to provide for appropriate adjustment to the LTCH PPS, including updates.

We also disagree with commenters that the proposed RY 2009 standard Federal rate would produce a retroactive effect and is tantamount to retroactive rulemaking. We note that the RY 2009 standard Federal rate will be prospectively applied to discharges beginning on July 1, 2008. That is, while our update for RY 2009 removed the benefit of

the RY 2008 update of 0.71 percent that had been finalized in the RY 2008 final rule, it can hardly be considered to have a "retroactive effect" since as the proposed (and final) update will not result in recoupment of any payments made for RY 2008.

Comment: Commenters also disagreed with the magnitude of the proposed 0.9 percent adjustment to account for coding and documentation changes that occurred between FY 2005 and FY 2006 that did not reflect increased patient severity. Specifically, with respect to our calculation of the apparent increase in case-mix (apparent increase equals observed increase minus real increase), some commenters disagreed with our use of 1 percent as a proxy for the real increase in case-mix for LTCHs based on a study of acute-care hospitals conducted by RAND using data from 1987 to 1988. Several commenters stated that data from the RAND study do not provide sufficient justification for the adjustment and that more current, relevant data are required for sufficient justification. Specifically, several commenters stated that the 20 year old RAND study was not a valid source of information on real case-mix growth in LTCHs because the study focused on short-term acute care hospitals, and that data from the RAND study is outdated and should not be relied upon. Some commenters stated that due to the age of the RAND study, it would not capture real case-mix growth that may have occurred in the intervening period as a result of changes in health care delivery patterns, increases in the prevalence of chronic conditions, or changes in the specialty mix of LTCHs. Specifically, they stated that there are legitimate reasons to support that "real" case-mix has indeed increased above the level estimated by the RAND study in the ensuing years. For example, they believe that factors such as longer life expectancy of beneficiaries, the migration of less sick and younger Medicare beneficiaries to Medicare

Advantage, changes in the specialty mix of LTCHs, and generally, increasing proportions of beneficiaries that are suffering from multiple chronic diseases, all would contribute to a higher "real" case-mix than the estimate provided by the RAND study. In addition, one commenter believed that use of the RAND data was not consistent with CMS audit requirements concerning hospitals use of data from a contemporaneous time period for cost allocation. In addition, instead of relying on an estimate of real case-mix growth from the RAND study, some commenters believed that CMS should assume that all observed case-mix growth is real or should use observed case-mix growth adjusted to remove any providers with atypical case-mix changes as a proxy for real case-mix growth.

MedPAC in its comments on the proposed rule stated that it believes CMS is justified in making adjustments to payments to take into account case-mix increases resulting from changes in coding practices. However, MedPAC expressed concern that it was difficult to know whether the RAND study findings reflected current growth in real case-mix for LTCHs, and urged CMS to pursue more up-to-date information for future adjustments. In their comments, MedPAC also noted that in their March 2008 report they had recommended a lower update than the one CMS had proposed even after the adjustment for the apparent increase in case-mix.

Response: In the RY 2009 proposed rule, consistent with our previous methodology, we proposed to use the RAND study estimate of 1 percent as the proxy for the real case-mix change to determine the "apparent" case-mix change (which based on FY 2006 LTCH claims data is 0.9 percent). While the case-mix parameters from the RAND study are based on IPPS data for acute-care hospitals, we believe they are an

appropriate proxy for real case-mix growth in LTCHs due to similarities between LTCHs and acute care hospitals. The types of patients treated by LTCHs are similar to the types of patients treated in IPPS acute care hospital step down units. As described in more detail in the RY 2009 LTCH PPS proposed rule (73 FR 5374 to 5376), we contracted with Research Triangle Institute, International (RTI) for a study evaluating the feasibility of developing patient and facility level characteristics for LTCHs that could distinguish LTCH patients from those treated in other hospitals. Results from the RTI study, including findings from technical expert panels, indicate that patients treated in LTCHs and IPPS acute care hospital step-down units are very similar. In addition, as we have discussed in many previous LTCH PPS proposed and final rules, acute-care hospitals paid under the IPPS and LTCHs paid under the LTCH PPS have much in common. Hospitals paid under both systems are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program. LTCHs are certified as acute care hospitals but are classified as LTCHs for payment purposes solely because such hospitals generally have an inpatient ALOS of greater than 25 days (as set forth in section 1886(d)(1)(B)(iv)(I) of the Act). Furthermore, the LTCH PPS uses the same patient classification system that is used under the IPPS. Although there have been some modifications over time, the CMS –DRG system in place in IPPS hospitals during the time of the RAND study is generally the same base DRG system used in LTCHs between 2005 and 2006. In addition, several LTCH PPS payment policies, such as the area wage adjustment (§ 412.525(c)), COLA for Alaska and Hawaii (§ 412.525(b)), and high cost outlier (HCO) policy (§ 412.525(a)) are modeled after similar IPPS policies. In summary, due to the similarities between LTCH hospitals and

acute care hospitals, including similarity in the patients treated by LTCHs and acute care step down units, we believe it is appropriate to use the RAND study of real case-mix growth in acute care hospitals as a proxy for real case-mix growth LTCHs.

Furthermore, although the data in the RAND study are not new, we continue to believe it is the best information available at this time to provide a proxy for real case-mix growth in LTCHs throughout this response. The methodology used by the RAND study to identify the real increase versus apparent increase in case-mix was very rigorous, involving chart abstraction data, claims data, and sophisticated statistical analyses. In the RY 2008 LTCH PPS proposed rule, we solicited comments on other data sources that could be used to determine a proxy for real LTCH PPS case-mix change besides the RAND study. While some commenters on the RY 2008 and RY 2009 proposed rules stated that we should assume all case-mix growth is real or we should use the observed case-mix increase adjusted to eliminate any provider with atypical case-mix changes as a proxy for real case-mix growth, the commenters did not provide any data justifying these assertions and we did not receive any comments providing an alternative data source on real case-mix growth for LTCHs. With regard to the comments that the RAND study would not reflect real case-mix growth that may have occurred in the time period after the RAND study (for example due to changes in health care delivery patterns, increases in the prevalence of chronic conditions, aging of the population, or changes in the specialty mix of LTCHs), we note that both before, during, and, after the time period examined by the RAND study, there are likely to be various factors driving real increases in case-mix. At this time, we are not aware of any data demonstrating that the factors contributing to increased case-mix in the time period after the RAND study would lead to

faster growth in real case-mix between FY 2005 and FY 2006 than the factors contributing to real case-mix growth in the time period examined by the RAND study (FY 1987 to FY 1988). Accordingly, we continue to believe that it is appropriate to use the RAND study, which was based on rigorous analytical and statistical methods, as a proxy for real case-mix growth in LTCHs in this RY 2009 LTCH PPS final rule, as we did in the RY 2008 final rule.

With respect to the comment that use of the RAND data is not consistent with CMS requirements for hospitals to use contemporaneous data for cost allocation as part of the cost reporting process, the timeframes applicable to hospital for compiling their cost report data are not relevant to the timeframes used to establish the LTCH PPS payment rates and the update to the LTCH PPS Federal rate. Although CMS uses hospitals cost reporting data as part of its calculation of the LTCH PPS rates, the hospital cost reporting process and the process CMS uses to establish PPS rates are separate processes, governed by different requirements. The LTCH PPS is a per discharge payment system based on prospectively set rates. To establish payment rates, we use the most recently available claims data and cost report data, however, like other prospective payment systems, there are time lags in the data available to establish the prospective payment rates. Typically, the LTCH PPS payment rates are established based on claims data from 2 years prior and cost-report data from 3 to 4 years prior. We also consistently use the most recent available data to determine the appropriate annual update factor. Accordingly, for this final rule we used the most recent available data, including the most recent estimate of the RPL market basket for July 1, 2008 through September 30, 2009 and the case-mix data from FY 2006, to establish the 2.7 percent update factor for RY

2009. Furthermore, as discussed above, we believe the RAND study represents the best information on real case-mix increases available at this time.

For all of the reasons discussed previously, we believe it is appropriate in calculating the RY 2009 update to continue to use 1 percent as a proxy for real case-mix growth in LTCHs based on the RAND study, as we did for the RY 2008 update. Accordingly, since the observed CMI change for FY 2006 is estimated at 1.9 percent (based on the most recent available LTCH case-mix data from FY 2006 as compared to FY 2005), accounting for the real CMI change of 1.0 percent, we estimate that 0.9 percent (1.9 – 1.0 = 0.9) of that increase reflects CMI increase that is due to changes in coding practices (rather than patient severity).

Finally, we agree with MedPAC that it would be beneficial to pursue more recent information on real case-mix growth in LTCHs for the future, particularly since we recently changed patient classification systems. As discussed in the FY 2009 IPPS proposed rule (73 FR 23541 and 23542), we are currently developing plans to evaluate case-mix growth in acute-care IPPS hospitals under the MS-DRG system. In conjunction with these efforts, we intend to examine case-mix growth in LTCHs under the MS-LTC-DRG system and re-examine the issue of real case-mix growth in LTCHs.

Comment: Some commenters stated that it is inappropriate to use the lower end (1.0 percent) of the range of real case-mix growth (1.0 percent to 1.4 percent) from the RAND study. These commenters indicated that consistency with the IPPS policy was not sufficient justification for adopting 1 percent, rather than 1.4 percent, as a proxy.

Response: As discussed in more detail above, LTCH hospitals paid under the LTCH PPS have much in common with acute care hospitals paid under the IPPS,

including being required to meet the same Medicare certification criteria, being paid under the same patient classification system, and having several LTCH PPS payment policies modeled after similar IPPS policies. In addition, as discussed previously, results from RTI's research indicates that patients treated by LTCHs are very similar to patients treated in IPPS acute care hospital step down units. In the RY 2008 final rule we adopted the more conservative 1.0 percent (rather than the 1.4 percent) as a proxy for real CMI growth because it is consistent with what is used under the IPPS and we believed the similarities between LTCHs and acute care hospitals are significant as explained previously. For a more detailed discussion on the 1.0 percent for real CMI increase utilized in the IPPS, see the FY 2007 IPPS final rule (71 FR 48156 through 48158), and the FY 1994 IPPS proposed rule (58 FR 30444). In the RY 2008 proposed rule, we solicited comments on other data sources that could be used to determine a proxy for real LTCH PPS case-mix change besides the RAND study. While, as discussed above, some commenters on the RY 2008 and RY 2009 proposed rules asserted that we should assume real case-mix is equal to observed case mix or we should use the observed case-mix increase adjusted to eliminate any provider with atypical case-mix changes as a proxy for the real case-mix increase, the commenters did not provide any data justifying these assertions and, we did not receive any comments providing an alternative data source on real case-mix growth for LTCHs. Lacking any data to the contrary and for the reasons discussed above and in the previous responses, we continue to believe that similarities between LTCHs and acute care hospitals justify using the same proxy from the RAND study for real case-mix growth. Thus, as proposed, we are adopting the 1.0 percent proxy

for real case-mix growth for LTCHs that is currently used under the IPPS for acute care hospitals.

Comment: Some commenters stated that there was little potential for the case-mix of LTCHs to increase as a result of changes in coding practices. Some commenters believed that in establishing a policy of annually updating the LTC-DRGs (now the MS-LTC-DRGs) and relative weights in a budget neutral manner, the RY 2008 LTCH PPS final rule and FY 2008 IPPS final rule indicated that growth in apparent case-mix was no longer a concern, and thus these commenters believed there is no reason for an adjustment for an apparent increase in case-mix in RY 2009. These commenters stated that CMS' continued use of an adjustment for "apparent" case-mix increases is inconsistent with CMS' rationale in implementing budget neutral MS-LTC-DRG relative weights.

Other commenters stated that most LTCH patients fall into high case-mix payment categories already or are paid outside of the LTCH payment system due to outlier status, and thus any case-mix changes are more likely to be real than the result of coding improvements. A few commenters also questioned the need for an adjustment for apparent increases in case-mix with the adoption of MS-LTC-DRGs, and asked how could "…a behavioral offset [of 0.9 percent] be suggested when the new system [that is, the MS-LTC-DRGs] was specifically designed to stratify acuity across DRGs?"

Response: In response to the commenters that question why we have proposed, at this time, a 0.9 percent adjustment to account for case-mix changes due to improved documentation and coding that are not due to increased patient acuity, when we have just adopted the MS-LTC-DRGs, we note that the proposed 0.9 percent adjustment is to

account for case-mix changes in coding that occurred in FY 2006, a year prior to the adoption of the MS-LTC-DRGs. With respect to the comments asserting that there is little potential for apparent case-mix increases because most LTCH patients fall into high case-mix payment categories or receive outlier payments, we disagree. While in FY 2006 the potential for apparent increases in case-mix due to shifts within base DRGs may have been limited to the extent that a substantial portion of LTCH patients were already in an LTC-DRG with a CC rather than an LTC-DRG without a CC, we believe there was still potential for apparent increases in case-mix due to shifts across base DRGs. In addition, only a small portion of LTCH PPS cases receive high cost outlier payments, and thus we believe the existence of high cost outliers has little impact on the potential for apparent case-mix increases.

We also disagree with comments suggesting that our proposal to adjust for apparent CMI growth is inconsistent with CMS' rationale for implementing the MS-LTC-DRG relative weights in a budget neutral manner. Specifically, in the RY 2008 LTCH PPS proposed and final rules, we explained that we considered whether to establish a policy of making annual changes to the LTC–DRG classifications and recalibrating the LTC–DRG relative weights in a budget neutral manner. Previously, we had not implemented the annual changes to the LTC–DRG classifications and the recalibration of the LTC–DRG relative weights in a budget neutral manner because we believed that past fluctuations in the LTC-DRG relative weights were primarily due to changes in LTCH coding practices and we believed that changes in the LTCH PPS payment rates, including the LTCH relative weights, should accurately reflect changes in LTCHs' true cost of care. Therefore, prior to RY 2008, we did not update the LTC-DRGs

in a budget neutral manner because we did not want to build apparent CMI changes permanently into the LTCH PPS payment rates. In the RY 2008 LTCH PPS final rule, we stated that an analysis of the most recent available LTCH claims data show a steady decrease in the observed growth in the case-mix index from year to year since FY 2003 (the observed case-mix change between FY 2003 and FY 2004 is 6.75 percent, between FY 2004 and FY 2005 is 3.49 percent, and between FY 2005 and FY 2006 is estimated to be 1.9 percent). With the substantial decline in observed case-mix growth between FY 2004 and FY 2006 noted above, we indicated that we believed the most recent available LTCH claims data (FY 2006) supports our belief that observed case-mix growth was now primarily the result of real increases and that changes in LTCH coding practices that resulted in fluctuations in the LTC-DRG relative weights appeared to be stabilizing. Therefore, we believe it appropriate to establish a policy of making annual changes to the LTC–DRG classifications and recalibrating the LTC–DRG relative weights in a budget neutral manner since budget neutrality would provide stability and predictability in LTCH PPS payments.

While we believed apparent case-mix growth declined substantially between FY 2004 and FY 2006, the RY 2008 LTCH PPS final rule reflects our belief that apparent CMI growth has not been eliminated entirely. We weighed the benefits of predictability and stability of payment against the fact that claims data reflect changes due to apparent CMI growth. As a result, we believed that the advantages of budget neutrality discussed previously outweighed any disadvantages such as the potential for fluctuations in the relative weights from apparent increases in case-mix. Furthermore, the adoption of budget neutral MS-LTC-DRG relative weights does not preclude the need for

CMS to adjust for any apparent case-mix increase that CMS identifies through our ongoing monitoring of the LTCH payment system. While we would not expect the growth in apparent case-mix in FY 2006 to be as large as observed in the early years of the LTCH PPS, since hospitals have had more experience under this DRG-based payment system, we have no reason to believe that the potential for apparent case-mix growth has been eliminated entirely since with any DRG system there can be potential for apparent changes in case-mix. Consequently, we continue to believe it is appropriate to calculate the observed increase in case-mix, and identify the portion that is the result of an apparent increase, in order to prevent payment increases that do not reflect real increases in the severity of illness.

In addition, we believe that the adoption of the MS-LTC-DRGs in FY 2008, which better take into account severity of illness in Medicare payment rates, is likely to encourage LTCHs to improve their documentation and coding of patient diagnoses and is likely to result in further apparent increases in case-mix in the future, as discussed in more detail in the FY 2008 IPPS final rule (72 FR 47297 to 47298). As discussed in the FY 2008 IPPS final rule (72 FR 47298 through 47299), since we have established this mechanism to adjust LTCH payments to account for the effect of changes in coding and documentation in a prior period which is based on actual LTCH data, we would continue to monitor the LTCH payment system and should we detect an "apparent" case-mix increase due to the adoption of the MS-LTC-DRG classification system, we would propose appropriate adjustments to account for that case-mix increase that is not due to increased patient severity. Also, as discussed in the FY 2008 IPPS final rule, if CMS is able to estimate an appropriate adjustment factor applicable to LTCHs, CMS would

propose an adjustment factor to LTCHs to account prospectively for coding and documentation changes.

Comment: Some commenters believe CMS has strayed from the basic purpose of the market basket update which is to account for the expected increase in prices for the upcoming year. The commenters portrayed the proposed 2.6 percent update factor for RY 2009 as an "inappropriate" and "unwarranted" reduced market basket update and has questioned CMS' authority to implement anything other than the full RPL market basket update to account for price inflation. The commenter further contends that CMS' reasoning for reducing the market basket update to account for "apparent" case mix increase in a previous period is not a factor that has anything to do with the function of the market basket. Instead of finalizing the update as proposed in the RY 2009 proposed rule, the majority of commenters strongly recommended that CMS apply an update based solely on the most recent estimate of the RPL market basket without an adjustment for case mix changes that are not due to increased patient severity. In contrast, MedPAC reiterated its recommendation included in its March 2008 Report to the Congress, suggesting the Secretary consider a lower update factor (than the 2.6 percent that was proposed).

Response: Section 123 of the BBRA, as amended by section 307(b) of the BIPA, provides that the Secretary may specify appropriate adjustments to the long-term care hospital payment system, including updates. This broad discretionary authority includes our ability to make adjustments in determining the annual update to the Federal rate for case-mix changes resulting from coding changes that do not reflect real change in case-mix regardless of whether such adjustment is for anticipated case-mix changes or

case-mix changes that occurred in a previous time period. We note that in previous years, we have determined the annual update to the LTCH PPS standard Federal rate based on two elements: 1) a positive adjustment to account for the LTCH PPS market basket estimate in full, and 2) a negative adjustment to account for case-mix changes in a prior period that were not due to increased patient severity. Specifically, the adjustments for coding and documentation changes implemented in the RY 2007 and RY 2008 final rules were based on actual LTCH case-mix data from FY 2004 and FY 2005, respectively (71 FR 27820 through 27822 and 72 FR 26887through 26890). Based upon a CMI analysis using the most recent available LTCH claims data (FY 2006 MedPAR files), we continue to believe that within the observed case-mix change for FY 2006, there remains some portion of "apparent" case-mix change.

As stated above, and as we discussed in the proposed rule, our proposed update for RY 2009 included the full increase of the 15-month RPL market basket estimate based on the best available data at the time (which was 3.5 percent). Therefore, our proposed (and final) update factor does account for the expected increase in prices for the upcoming year (RY 2009). However, the full market basket increase is not the only factor used in determining the proposed update for RY 2009. As discussed above, consistent with our historical practice and the Secretary's broad discretionary authority to determine appropriate updates under the LTCH PPS, in addition to proposing to use the most recent estimate of the full RPL market basket increase, we proposed an adjustment to account for case-mix changes that were not due to increased patient severity from a prior period in determining the proposed update for RY 2009.

In this final rule, as we proposed, we are using the most recent available 15-month RPL market basket estimate, which for the final rule is 3.6 percent as discussed above in section IV.C. of this preamble. As also discussed in this section, we are finalizing the proposed -0.9 percent adjustment to account for the increase in case-mix in the prior period (FY 2006) that resulted from changes in coding practices rather than increased patient severity. Therefore, in this final rule, to update the standard Federal rate for RY 2009 in accordance with our established process, we are finalizing an update factor of 2.7 percent which is calculated based on two elements: 1) a positive adjustment of 3.6 percent to account for the most recent RPL market basket estimate in full, and 2) a negative adjustment of 0.9 percent to account for case-mix changes that were not due to increased patient severity. We note that in commenting on the proposed rule, MedPAC reiterated its recommendation included in its March 2008 Report to the Congress, suggesting the Secretary consider a lower update for LTCHs for RY 2009. In the March 2008 Report to Congress (page 231), the Commission recommended that the Secretary update LTCH payments by the LTCH PPS market basket index (that is, the RPL Market basket) less the Commission's adjustment for productivity growth (1.5 percent). Under the market basket estimates available at that time, MedPAC's recommendation would be to update the LTCH PPS payment rates by 1.6 percent.

Comment: Some commenters believed there is no regulatory basis for CMS to adjust the market basket update to account for the apparent increase in case-mix for a previous year and that such an adjustment is inconsistent with the purpose of a market basket adjustment. One commenter also stated that making a case-mix adjustment to future payments to account for past payments violates the philosophy of a prospective

payment system, and is inconsistent with other policies such as not correcting the market basket when the final data on the market basket for a specific time period turns out to be different from the estimate used as the basis of the update. Another commenter believed that it was inappropriate to make an adjustment for the apparent increase in case-mix that occurred during the 12 months from FY 2005 to FY 2006 when the final rule is covering a 15-month rate year.

Response: Section 123 of the BBRA as amended by section 307(b) of the BIPA conferred upon the Secretary broad discretion to determine the standard rate and make appropriate adjustments to the system. We note that while § 412.523(c)(3) specifies the update to the standard Federal rate for each year since the implementation of the LTCH PPS in FY 2003 (that is, RYs 2004 through RY 2008), neither the statute nor the current regulations specifically require that the Secretary automatically apply a market basket increase to prospective years although we have done this in prior years, and are doing so in this final rule.

As we discussed in greater detail in the RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), while we continue to believe that an update to the LTCH PPS Federal rate year should be based on the most recent estimate of the LTCH PPS market basket, we believe it appropriate that the rate update also reflect an adjustment to account for changes in coding practices that do not reflect increased patient severity. Such an adjustment protects the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients (71 FR 27798 through 27820). Therefore, in determining the RY 2009 update to the LTCH PPS Federal rate, we believe it is appropriate to apply an adjustment to eliminate

the effect of coding or classification changes in a prior period (FY 2006) that do not reflect real changes in LTCHs' case-mix, for the reasons discussed above. As was the case when we determined the RY 2007 and RY 2008 update factors, this adjustment is necessary to account for improved coding (rather than increased patient severity) in prior years.

In addition, we do not agree with the comment that this adjustment is inconsistent with the philosophy of prospective payment system. This adjustment does not alter the fundamental aspect of the LTCH PPS, which is to make payment for a DRG based on a predetermined, fixed amount. Furthermore, the adjustment, while based on retrospective analysis of claims data, is applied prospectively to the LTCH PPS rates. Also, with respect to the commenter's concern that the adjustment for apparent increases in case-mix that occurred in a prior period is different from policies in other areas such as not adjusting the payment rates to reflect retrospective revisions to the market basket estimates, we note that there are numerous principles that we try to balance simultaneously when making policy decisions. Among these principles are appropriate payment, predictability, averaging, beneficiary access to appropriate care, and equity. With regard to the adjustment for the apparent increase in case-mix, given the potential for apparent increases in case-mix to lead to substantial inappropriate increases in payments over time without a corresponding increase in the severity of illness (or costs), we believe on balance it is in the best interest of the Medicare trust fund to make such an adjustment. With regard to an adjustment for revisions in the market basket estimates, given the typically small size of these market basket revisions, in the interest of predictable payments we have not made such an adjustment.

With respect to the appropriateness of applying the adjustment to a 15- month rate year, the adjustment is included permanently in the rate and thus the result would be the same regardless of whether RY 2009 is a 12-month or 15-month rate year. This is because the adjustments that we have made in prior years (that is, in RYs 2007 and RY 2008) and the adjustment we are making this year (in RY 2009) are cumulative.

Therefore, in this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, we are revising § 412.523(c)(3), to specify that, for discharges occurring on or after July 1, 2008 and on or before September 30, 2009, the standard Federal rate for RY 2008 will be updated by 2.7 percent, which is based on the most recent market basket estimate (3.6 percent) and an adjustment for the apparent increase in case-mix (0.9 percent) due to changes in coding practice rather than an increase in patient severity, as discussed in more detail subsequently. We note that the 2.7 percent update for RY 2009 that we are establishing in this final rule is higher than the 1.6 percent update recommended by MedPAC in their March 2008 report. While MedPAC's update recommendation was based on a 12-month rate year, we believe that if MedPAC were to revise its update recommendation for a 15-month rate year, its recommended update would still in all likelihood be lower than the update being adopted in this final rule due to the formula MedPAC used to calculate its update recommendation (that is, the market basket increase minus MedPAC's 1.5 percent estimate of productivity growth).

Comment: Commenters claim that the cumulative effect of our changes to the LTCH PPS over the last few years has reduced LTCH margins significantly. Some

commenters asserted that high profit margins had been one justification given in prior years' regulations for the adjustment in the update to account for case-mix increases that reflected changes in coding practices. The commenters pointed to the MedPAC March 2008 report which estimated negative margins of between -1.4 percent to -0.4 percent in 2008, and these commenters stated that an adjustment for the apparent increase in case-mix is not appropriate this year given the estimated negative margins.

Response: OACT's most recent estimate of LTCH inpatient Medicare margins is for FY 2006 (9.9 percent). While the 2006 margins appear to be substantial, we believe the 2006 margin estimates are unlikely to reflect the impact of the payment system changes that have occurred over the last two years, in particular those occurring in RY 2007 and RY 2008. Making estimates of the impact of recent payment system changes such as recalibrating the relative weights in 2007, adjusting for coding improvements, reducing aggregate payments for outliers, making changes to reimbursement for patients with the shortest length of stay (that is, short-stay outliers), and the "25 percent rule." MedPAC projected that margins will be between -1.4 percent and -0.4 percent for FY 2008. Given this analysis, MedPAC indicated in its March 2008 report that "LTCHs may not be able to accommodate growth in the cost of caring for Medicare beneficiaries in 2009 without an increase in the base rate." However, MedPAC's March 2008 report recommended an update of 1.6 percent for RY 2009 based on the market basket adjusted for MedPAC's estimate of productivity growth. The update that we are adopting in this final rule of 2.7 percent (which includes the 0.9 percent adjustment for the apparent increase in case-mix) is higher than the update proposed in the RY 2009 LTCH PPS proposed rule (2.6 percent) and higher than the

update recommended by MedPAC in its March 2008 report (1.6 percent). As noted previously, while the update recommended by MedPAC was based on a 12-month rate year, we believe that if MedPAC were to revise its update recommendation for a 15-month rate year, it would still in all likelihood be lower than the update being adopted in this final rule, Therefore, we do not believe it can be concluded from MedPAC's margin projections and update recommendation that the 2.7 percent update established in this final rule, which is based on the most recent estimate of the market basket increase and an adjustment for the apparent increase in case-mix, is inadequate since MedPACs update recommendation (which was issued contemporaneously with their margin analysis) is lower than the 2.7 percent update established in this final rule. Furthermore, we note that most of the reductions cited by the commenters and considered by MedPAC in their margin analysis were implemented by CMS in RY 2007 and RY 2008 and were reversed (for three years) by section 114 of the MMSEA. Therefore, we expect margins would be higher than projected taking into account these changes.

As more data become available, we intend to continue to monitor LTCHs' margins. In the past, we have observed that LTCHs have adapted to our regulatory changes by modifying their business model to maximize profitability while operating under the new changes. For example, when we implemented the 25 percent (or applicable percentage) threshold payment adjustment in FY 2005 for co-located LTCHs and satellites, we are aware that LTCHs shifted emphasis from developing co-located facilities to developing freestanding LTCHs. Thus, we believe LTCHs are likely to continue to respond to the payment changes in ways that mitigate the impact on their profitability.

Comment: One commenter recommended that CMS provide a full market basket update for all cases that are not paid on a full MS-LTC-DRG basis such as cases paid under the short stay outlier (SSO) policy or the 25 percent rule, stating that hospitals have no "practical opportunity for upcoding" such cases.

Response: Even for cases that will be paid on a full MS-LTC-DRG basis in RY 2009, we are providing a full market basket adjustment (3.6 percent), which is combined with an adjustment for the apparent increase in case-mix in a prior period (-0.9 percent), to yield a combined update of 2.7 percent. With respect to cases that are not paid on a full MS-LTC-DRG basis, we believe it is appropriate to apply the adjustment for apparent case-mix, where applicable, for several reasons. Under current law, SSO cases are paid the lower of 100 percent of estimated costs of the case; 120 percent of the MS-LTC–DRG per diem multiplied by the covered LOS of the case; the Federal prospective payment for the MS-LTC–DRG; or a blend of 120% of the LTC-DRG per diem amount and an amount that is comparable to what the case would be paid under the IPPS (computed as a per diem). The majority of SSO cases are not impacted by the market basket update or the adjustment for the apparent increase in case-mix because they are paid based on the estimated cost of the case which is determined by multiplying the covered charges for the case by the LTCH's CCR. For those SSO cases paid under the other payment options, we believe it is appropriate to apply the adjustment for the apparent increase in case-mix. The purpose of doing so is to adjust for apparent increases in case-mix that occurred under the LTCH PPS in a prior period (FY 2006). Whether there is potential for future apparent increases in case-mix in RY 2009 for these cases is not relevant to this adjustment because this adjustment is for a prior period.

Nevertheless, we disagree with the commenter's assertion that there is no potential for an apparent increase in case-mix for SSO cases paid under the 2nd and 4th options in the SSO payment formula described above because these options are based on DRGs. The payment amount for those cases is dependent on the MS-LTC-DRG to which the patient is assigned. In other words, the MS-LTC-DRG per diem amount, which is a component of the 2nd and 4th options in the SSO payment formula as described above, is computed based on the MS-LTC-DRG to which the case is grouped. Similarly, with respect to the 25 percent rule, notwithstanding the changes made to it by MMSEA, the payment amounts calculated under this policy are dependent upon the MS-LTC-DRG to which the case is assigned. As with any DRG system there is potential for apparent changes in case-mix because there can be shifts within or across base DRGs. Accordingly, for the reasons discussed above, we are not adopting the commenter's suggestion to apply the full market basket update without an adjustment for the apparent increase in case-mix that occurred in FY 2006 to all cases that are not paid on a full MS-LTC-DRG basis.

In summary, as we proposed, we are establishing an update to the standard Federal Rate for RY 2009 based on the most recent estimate of the full LTCH PPS market basket estimate which went up to 3.6 percent (as discussed above in section IV.C.2. of this preamble) and an adjustment to account for the increase in case-mix in the prior period (FY 2006) that resulted from changes in coding practices of -0.9 percent. Therefore, the update factor to the standard Federal rate for RY 2009 is 2.7 percent (3.6 – 0.9 = 2.7). That is, under the broad authority conferred upon the Secretary under the BBRA and the BIPA, we specify under §412.523(c)(3)(v), that, for discharges occurring on or after July 1, 2008 and on or before September 30, 2009, the standard Federal rate

from the previous year would be updated by 2.7 percent. In determining the standard Federal rate for RY 2009, we applied the 2.7 percent update to the RY 2008 standard Federal rate of $38,086.04, which is the same standard Federal rate applicable for discharges occurring during RY 2007, consistent with section 1886(m)(2) of the Act. Consequently, we are establishing a standard Federal rate for RY 2009 of $39,114.36, which will be effective for LTCH discharges occurring on or after July 1, 2008 and through September 30, 2009. We note that the President's FY 2009 budget proposal include the provision that would provide for a zero percent update to the Federal rate for 2009 through 2011, and then would reduce the market basket update to the Federal rate by 0.65percent in each year thereafter.

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

1. Adjustment for Area Wage Levels

a. Background

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

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

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

(1) Background

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels under §412.525(c), the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index based on the labor market area in which the LTCH is located. In the RY 2006 LTCH PPS final rule (70 FR 24184 through 24185), in regulations at §412.525(c), we revised the labor market area definitions used under the LTCH PPS effective for discharges occurring on or after July 1, 2005 based on the Office of Management and Budget's (OMB's) Core Based Statistical Area (CBSA) designations based on 2000 Census data. We made this revision because we believe that those new CBSA-based labor market area definitions will ensure that the LTCH PPS

wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. As set forth in existing §412.525(c)(2), a LTCH's wage index is determined based on the location of the LTCH in an urban or rural area as defined in §412.64(b)(1)(ii)(A) through (C). An urban area under the LTCH PPS is currently defined at §412.64(b)(1)(ii)(A) and (B). Under §412.64(b)(1)(ii)(C), a rural area is defined as any area outside of an urban area.

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

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

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

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

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

- Mauldin, South Carolina and Easley, South Carolina qualify as new principal cities of the Greenville-Mauldin-Easley, South Carolina CBSA (CBSA code 24860).
- Conway, Arkansas qualifies as a new principal city of the Little Rock-North Little Rock-Conway, Arkansas CBSA (CBSA code 30780) .
- Goleta, California qualifies as a new principal city of the Santa Barbara-Santa Maria-Goleta, California CBSA (CBSA code 42060).
- Franklin, Tennessee qualifies as a new principal city of the Nashville-Davidson-Murfreesboro-Franklin, Tennessee CBSA (CBSA code 34980).
- Fort Pierce, Florida no longer qualifies as a principal city of the Port St. Lucie-Fort Pierce, Florida CBSA; the new designation is Port St. Lucie, Florida CBSA (CBSA code 38940).
- Essex County, Massachusetts Metropolitan Division was renamed as the Peabody, Massachusetts Metropolitan Division, which changed the CBSA code from 21604 to 37764.

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

We noted in the RY 2009 LTCH PPS proposed rule that we are currently not aware of any LTCHs located in the two new proposed CBSAs (that is, proposed CBSA 29420 and proposed CBSA 37380), and the six proposed revisions to the CBSA designations would only revise the CBSA titles (and the CBSA code for the CBSA that consists of Essex C ounty, MA).) We also noted that these proposed revisions to the

CBSA-based designations were adopted under the IPPS effective beginning October 1, 2007 (72 FR 47308 through 47309).

We received no comments on the two new CBSAs and the revision of designations for six areas (based on OMB Bulletin No. 07-01) that were presented in the RY 2009 LTCH PPS proposed rule (73 FR 5363). In this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, as we proposed, we are applying these changes to the current CBSA-based labor market area definitions and geographic classifications used under the LTCH PPS effective for discharges occurring on or after July 1, 2008. We believe these revisions to the LTCH PPS CBSA-based labor market area definitions, which are based on the most recent available data, will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Accordingly, the RY 2009 LTCH PPS wage index values presented in Tables 1 and 2 in the Addendum of this final rule reflect the revisions to the CBSA-based labor market area definitions described above.

(3) Clarification of New England Deemed Counties

As we did in the proposed rule, we are also taking this opportunity to address the change in the treatment of "New England deemed counties" (that is, those counties in New England listed in §412.64(b)(1)(ii)(B) that were deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983) that was made in the FY 2008 IPPS final rule with comment period. These counties include the following:

Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Of these five "New England deemed counties," three (York County, Sagadahoc County, and Newport County) are also included in metropolitan statistical areas defined by OMB and are considered urban under both the current IPPS and LTCH PPS labor market area definitions in §412.64(b)(1)(ii)(A) (they will also be urban under the conforming changes to §412.503 that we are making in this final rule). The remaining two, Litchfield County and Merrimack County, are geographically located in areas that are considered rural under the current IPPS (and LTCH PPS) labor market area definitions (however, they have been previously deemed urban under the IPPS in certain circumstances as discussed below).

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

provider wage indices would be addressed in the respective payment system rules. Accordingly, as stated above and as we did in the proposed rule, we are taking this opportunity to clarify the treatment of "New England deemed counties" under the LTCH PPS in this final rule.

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

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

As noted above, existing §412.525(c)(2) indicates that the terms "rural" and "urban" as areas are defined according to the definitions of those terms in §412.64(b)(1)(ii)(A) through (C). As Litchfield County, CT and Merrimack County, NH

would be considered rural areas in accordance with our regulations at (§412.525(c)(2), these two counties will be "rural" under the LTCH PPS effective with the next update of the LTCH PPS payment rates, which will be July 1, 2008 (Under the LTCH PPS effective for discharges on or after July 1, 2008, Litchfield County, CT and Merrimack County, NH are not urban under §412.64(b)(1)(ii)(A-B) and therefore are rural under §412.64(b)(1)(ii)(c) in the regulations). We note that Litchfield and Merrimack Counties will also be rural under our revision to§412.503, discussed in greater detail below, that incorporates the existing definitions of "urban" and "rural" areas. Therefore, Litchfield County, CT and Merrimack County, NH will be considered "rural" effective for LTCH PPS discharges occurring on or after July 1, 2008, and will no longer be considered as being part of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700 (Manchester-Nashua, NH), respectively. We note that currently we are not aware of any LTCHs located in either Litchfield County, CT or Merrimack County, NH. We also note that this policy is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS. In addition, as discussed above, in this section, effective for discharges on or after July 1, 2008, §412.64(b)(1)(ii)(B) is no longer applicable under the LTCH PPS. We note that we received no comments on this clarification.

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

Under the current regulations at §412.525(c), the labor-related portion of the LTCH PPS Federal rate is adjusted to account for geographical differences in the area wage levels using an appropriate wage index to reflect the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area) of the hospital

compared to the national average level of hospital wages and wage-related costs annually. Currently, the application of the wage index under existing §412.525(c)(2) is made on the basis of the location of the facility in an urban or rural area as defined in §412.64(b)(1)(ii)(A) through (C) (in 42 CFR Part 412 subpart D).

In light of the regulatory construct discussed above where existing §412.525(c) indicated that the terms "rural area" and "urban area" as defined according to the definitions of those terms" under the IPPS in 42 CFR Part 412 subpart D, in the proposed rule, we explained that we believe it may be administratively simpler to have the LTCH PPS urban and rural labor market area definitions self-contained in (§412.503) 42 CFR Part 412 subpart O rather than cross-referring to the definitions of urban and rural in the IPPS regulations in 42 CFR Part 412, Subpart D. We also noted that this approach is similar to the change we made in §412.525(a) for high cost outliers and §412.529 for short-stay outliers in the FY 2007 IPPS final rule when we embedded within Subpart O the regulatory provisions concerning the determination of cost-to-charge ratios (CCRs) and the reconciliation of outlier payments (71 FR 48115 through 48122). Therefore, in the proposed rule (72 FR 5364), under the broad authority of §123 of the BBRA as amended by §307(b) of BIPA we proposed to codify in §412.503 the definitions for "urban area" and "rural area." We stated that the proposed definitions for "urban area" and "rural area" in §412.503 would incorporate the provisions of §412.62(f)(1)(ii) and (f)(1)(iii) as well as §412.64(b)(1)(ii)(A) through (C) in the regulations. Furthermore, we also explained that the definition of "urban area" at §412.64(b)(1)(ii)(B) is no longer applicable under the LTCH PPS effective for discharges occurring on or after July 1, 2008 (as explained above in section IV.F.1.b.3.), and therefore, the only

remaining definition of "urban area" will be that of a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget. Thus, we omitted the language of §412.64(b)(1)(ii)(B) from the proposed definition of "urban area" that would be applicable to discharges occurring on or after July 1, 2008 in proposed §412.503. We, however, included the language from §412.64(b)(1)(ii)(A) in the proposed definition of "urban area" in the regulations that would be applicable to discharges occurring on or after July 1, 2008 in proposed §412.503. For the reason just described, we explained that the proposed definitions of "urban" and "rural" that would be effective for discharges occurring on or after July 1, 2008 (in subparagraph (3) in both the proposed definition of "rural area" and the proposed definition of "urban area") vary slightly from the wording in the current regulations at §412.64(b)(1)(ii)(A) through (C); however, substantively the definitions are the same. We believe that the slight difference in the wording of proposed §412.503 more precisely conveys the treatment of New England deemed counties under the LTCH PPS, as discussed above. As a conforming change, we also proposed to replace the cross-references to §412.62(f)(1)(iii) and §412.64(b)(1)(ii)(A) through (C) of the regulations in existing §412.525(c) with references to the proposed definitions of "urban area" and "rural area" at §412.503. Therefore, in the proposed rule, we also proposed to revise §412.525(c) to specify that the application of the LTCH PPS wage index would be made on the basis of the location of the LTCH in an urban or rural area as defined in proposed §412.503.

We received no comments on our proposal to codify the definitions of urban and rural under 42 CFR Part 412 Subpart O in §412.503 or our proposal to replace the cross-references to the definitions of urban and rural set forth under 42 CFR Part 412 Subpart D

in existing §412.525(c) with references to the proposed definitions of "urban area" and "rural area" at §412.503. Accordingly, in this final rule, under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, as proposed, we are codifying the definitions for "urban area" and "rural area" in §412.503 for the reasons discussed above. As proposed, the definitions for "urban area" and "rural area" in §412.503 incorporate the provisions of §412.62(f)(1)(ii) and (f)(1)(iii) as well as §412.64(b)(1)(ii)(A) through (C). However, as discussed above, since the definition of "urban area" at §412.64(b)(1)(ii)(B) is no longer applicable under the LTCH PPS effective for discharges occurring on or after July 1, 2008, the only remaining definition of "urban area" will be that of a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget. Thus, we omitted the language of §412.64(b)(1)(ii)(B) from the definition of "urban area" that will be applicable to discharges occurring on or after July 1, 2008 in §412.503. However, we included the language from §412.64(b)(1)(ii)(A) in the definition of "urban area" that will be applicable to discharges occurring on or after July 1, 2008 in proposed §412.503.

Additionally, as proposed, as a conforming change, we are revising existing §412.525(c) by replacing the cross-references to §412.62(f)(1)(iii) and §412.64(b)(1)(ii)(A) through (C) with references to the newly added definitions of "urban area" and "rural area" at §412.503. Therefore, in this final rule, we are also revising §412.525(c) to specify that the application of the LTCH PPS wage index would be made on the basis of the location of the LTCH in an urban or rural area as defined in §412.503. As discussed in section VI.G.3. of this final rule, we are also making conforming changes to the regulations governing short-stay outlier payments (at §412.529) and the special

payment provisions for co-located LTCHs (at §412.534) and free-standing LTCHs (at §412.536), which refer to the definition of urban and rural under the LTCH PPS. We note that, as proposed, this revision to §412.525(c) includes the deletion of existing subparagraphs (1) and (2) since the newly added definitions of "urban area" and "rural area" at §412.503 contain the definitions for the respective time periods covered in existing §412.525(c)(1) and (2).

c. Labor-Related Share

In the August 30, 2002 LTCH PPS final rule (67 FR 56016), we established a labor-related share of 72.885 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all other labor-intensive services) and capital costs of the excluded hospital with capital market basket based on FY 1992 data. We did not revise the labor-related share in RYs 2004 through 2006 while we conducted further analysis to determine the most appropriate methodology and data for determining the labor-related share under the LTCH PPS (70 FR 24182). After our research into the labor-related share methodology was completed, we revised the labor-related share under the LTCH PPS in the RY 2007 final rule (71 FR 27829). Specifically, beginning in RY 2007, we established a labor-related share based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all other labor-intensive services) and capital costs of the RPL market basket based on FY 2002 data, as it is the best available data that reflect the cost structure of LTCHs.

Consistent with our historical practice, the labor-related share currently used under the LTCH PPS is determined by identifying the national average proportion of

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

In the proposed rule (73 FR 5364 through 5366), under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, consistent with our historical practice of determining the labor-related share, we proposed to revise the LTCH PPS labor-related share from 75.788 percent to 75.920 percent based on the sum of the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the FY 2002-based RPL market basket from the fourth quarter of 2007 forecast. Consistent with our proposal to consolidate the annual LTCH PPS updates by proposing to extend RY 2009 by 3 months, we proposed to use the 15-month RY 2009 RPL market basket to determine the proposed labor-related share for RY 2009. Furthermore, we proposed to use the FY 2002-based RPL market basket costs based on data from the fourth quarter of 2007 forecast to determine the labor-related share for the LTCH PPS during RY 2009, that is, effective for discharges occurring on or after July 1, 2008 and through September 30, 2009, because at that time it was the most recent available data. We note that in the proposed rule, we inadvertently indicated the proposed labor related share would be effective occurring on or after July 1, 2008 and before September 30, 2009 (73 FR 5365), when we meant to say through

September 30, 2009 which is consistent with the time period for RY 2009. Consistent with our historical practice of using the best data available, we also proposed that if more recent data are available to determine the labor-related share of the RPL market basket, we would use it for determining the RY 2009 LTCH PPS labor-related share in the final rule.

We received no comments on the proposed labor related share for RY 2009. As discussed in section IV.C.2. of this preamble, we now have data from the 1st quarter of 2008 forecast (with history through the 4th quarter of 2007) available for determining the labor-related share of the FY 2002-based RPL market basket. Based on this more recent data, in this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, consistent with our historical practice of determining the labor-related share by identifying the national average proportion of operating costs and capital costs that are related to, influenced by, or varies with the local labor market, we are revising the LTCH PPS labor-related share from 75.788 percent to 75.662 percent based on the sum of the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the FY 2002-based RPL market basket from the first quarter of 2008 forecast, as shown in Table II.

In this final rule, for RY 2009, we are using the FY 2002-based RPL market basket costs based on data from the first quarter of 2008 forecast to determine the labor-related share for the LTCH PPS for RY 2009 effective for discharges occurring on or after July 1, 2008 and through September 30, 2009, as this is the most recent available

data. The labor-related share for RY 2009 LTCH PPS continues to be determined as the sum of the relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year (FY 2002) and the (15-month) 2009 LTCH PPS rate year. As discussed in greater detail above in section IV.B. of this final rule, we are moving the LTCH PPS annual payment rate year beginning July 1st to a rate year beginning October 1st and will have a 15-month rate year for 2009 that is, July 1, 2008 through September 30, 2009. Accordingly, we are using the 15-month RY 2009 RPL market basket, discussed above, to determine the labor-related share for RY 2009 in this final rule. Based on the most recent available data, the sum of the relative importance for the 2009 LTCH PPS rate year for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) will be 71.719, as shown in Table II. The portion of capital that is influenced by the local labor market for this final rule, as was proposed, is still estimated to be 46 percent, which is the same percentage used when we established the current labor-related share in the RY 2008 LTCH PPS final rule. Based on the most recent available data, the relative importance for capital will be 8.572 percent of the FY 2002-based RPL market basket for the 2009 LTCH PPS rate year. As proposed, we are multiplying the estimated portion of capital influenced by the local labor market (46 percent) by the relative importance for capital (8.572 percent) to determine the labor-related share of capital for the 2009 LTCH PPS rate year. The result is 3.943 percent (0.46 x 8.572 percent), which we add to the 71.719 percent for the operating cost amount to determine the total labor-related share for the 2009 LTCH PPS rate year. Thus, based on the latest available data, we are establishing a labor-related share of 75.662 percent (71.719 percent + 3.943 percent)

under the LTCH PPS for the 2009 LTCH PPS rate year. As noted above in this section, the labor-related share in this final rule is determined using the same methodology as employed in calculating the current LTCH labor-related share (72 FR 26892) and the labor-related shares used under the IRF PPS and IPF PPS, which also use the RPL market basket.

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

TABLE II: RY 2008 Labor-Related Share Relative Importance and RY 2009 Labor-Related Share Relative Importance of the FY 2002-based RPL Market Basket

Cost Category	RY 2008 Relative Importance*	RY 2009 Relative Importance
Wages and Salaries	52.588	52.663
Employee Benefits	14.127	14.024
Professional fees	2.907	2.895
All other labor intensive services**	2.145	2.137
Subtotal	71.767	71.719
Labor share of capital costs	4.021	3.943
Total Labor-related share	75.788	75.662

* As established in the RY 2008 LTCH PPS final rule (72 FR 26892).
** Other labor intensive services includes landscaping services, services to buildings, detective and protective services, repair services, laundry services, advertising, auto parking and repairs, physical fitness facilities, and other government enterprises.

d. Wage Index Data

Historically, under the LTCH PPS, we have established LTCH PPS wage index values calculated from acute care IPPS hospital wage data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56019), since hospitals

that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report. Therefore, we would need to establish instructions for the collection of this LTCH data as well as develop some type of application and determination process before a geographic reclassification adjustment under the LTCH PPS could be implemented. Thus, the wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider. Acute care hospital inpatient wage index data are also used to establish the wage index adjustment used in other Medicare PPSs, such as the IRF PPS, IPF PPS, HHA PPS, and SNF PPS.

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

In the proposed rule (72 FR 5366), under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we proposed to use the same data collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004 that was used to compute the FY 2008 acute care hospital

inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act to determine the applicable wage index values under the LTCH PPS in RY 2009 because these data (FY 2004) are the most recent complete data available at that time. We proposed to continue to use IPPS wage data as a proxy to determine the proposed LTCH wage index values for RY 2009 because both LTCHs and acute-care hospitals are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program and they both compete in the same labor markets, and therefore, experience similar wage-related costs. We also noted that the IPPS wage data used to determine the proposed RY 2009 LTCH wage index values reflected our policy adopted under the IPPS beginning in FY 2008 that apportions the wage data for multi-campus hospitals' located in different labor market areas (CBSAs) to each CBSA where the campuses are located (For additional information see the FY 2008 IPPS final rule with comment (72 FR 47317 through 47320)). We also explained that the proposed RY 2009 LTCH PPS wage index values were computed consistent with the urban and rural geographic classifications (labor market areas) discussed in that same proposed rule and consistent with pre-reclassified IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS). The proposed RY 2009 wage index values also reflected our proposals, (which are discussed below), to establish wage index values in urban and rural areas in which there are no IPPS wage data from which to compute a wage index value under our methodology described above. (Additional details on this proposal, which we are finalizing without modification in this final rule, are discussed below or can be found in

the RY 2009 proposed rule (73 FR 5366).) We received no comments on our proposal to update the wage index values based on the most recent available data or our proposed methodology for computing the RY 2009 LTCH PPS wage index.

In this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, as proposed, we are using the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004) used to compute the FY 2008 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act to determine the applicable wage index values under the LTCH PPS in RY 2009 because these data (FY 2004) are the most recent complete data. (For information on the data used to compute the FY 2008 IPPS wage index refer to the FY 2008 IPPS final rule with comment period (72 FR 47308 through 47309, 47315)). As we explained in the proposed rule, we continue to use IPPS wage data as a proxy to determine the proposed LTCH wage index values for RY 2009 because both LTCHs and acute-care hospitals are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program and they both compete in the same labor markets, and therefore, experience similar wage-related costs. As also discussed in the proposed rule, we note that the IPPS wage data used to determine the RY 2009 LTCH wage index values reflects our policy adopted under the IPPS beginning in FY 2008 that apportions the wage data for multicampus hospitals' located in different labor market areas (CBSAs) to each CBSA where the campuses are located (For additional information see the FY 2008 IPPS final rule with comment period

(72 FR 47317 through 47320)). For the RY 2009 LTCH PPS wage index, which is computed from IPPS wage data submitted by hospitals for cost reporting periods beginning in FY 2004 (just like comparable to the FY 2008 IPPS wage index), we allocated salaries and hours to the campuses of two multicampus hospitals with campuses that are located in different labor areas, one in Massachusetts and another in Illinois. Thus, the RY 2009 LTCH PPS wage index values for the following CBSAs are affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI-MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974) and Lake County-Kenosha County, IL-WI (CBSA 29404) (refer to Table 1 in the Addendum of this final rule). As proposed, the RY 2009 LTCH PPS wage index values presented in this final rule were computed consistent with the urban and rural geographic classifications (labor market areas) discussed above in section IV.F.1.b. of this final rule and consistent with pre-reclassified IPPS wage index policy, that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS. Specifically, we note (as we did in the proposed rule) that the wage data of the IPPS hospitals located in Litchfield county, CT, and Merrimack county, NH, were included in the calculation of the RY 2009 LTCH PPS statewide rural wage index values for Connecticut and New Hampshire, respectively (rather than urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700 (Manchester-Nashua, NH), respectively). In addition, the RY 2009 wage index reflects the policy, which is discussed in greater detail below, we are establishing to determine wage index values in urban and rural areas in which there are no IPPS wage data from which to compute a wage index value under our methodology described above. As noted above,

the RY 2009 LTCH PPS wage index values in this final rule were computed from the same FY 2004 acute care hospital inpatient wage data that were used to compute the FY 2008 wage index currently used under the IPPS.

Also, as proposed in the RY 2009 proposed rule (73 FR 5366 through 5368), we are establishing a policy for determining LTCH PPS wage index values for labor market areas in which there is no IPPS hospital wage data from which to compute a wage index value under our methodology described above. In the RY 2009 proposed rule, we explained that currently, there are no LTCHs located in labor areas where there is no IPPS hospital wage data (or IPPS hospitals). However, we believed it was appropriate to establish a methodology for determining LTCH PPS wage index values for these areas in the event that in the future a LTCH should open in one of those areas. Thus, any LTCH that would open in an area in which there is no IPPS wage data for which to compute a wage index based on our established methodology would have a wage index value assigned to them for determining their LTCH PPS payments. Consistent with the proposed rule, in this final rule we are adopting the policy which provides that each year we will determine a wage index value for any area in which there is no IPPS wage data based on the methodologies described below. These policies for determining LTCH PPS wage index values for areas with no IPPS hospital wage data are consistent with the policies that have been established under other Medicare post-acute care PPSs, such as SNF and HHA, as well as the IPPS.

Specifically, as proposed, we are establishing a policy for determining a LTCH PPS wage index value for urban CBSAs with no IPPS wage data by using an average of all of the urban areas within the State to serve as a reasonable proxy for determining the

LTCH PPS wage index for an urban area without specific IPPS hospital wage index data. We believe that an average of all of the urban areas within the State would be a reasonable proxy for determining the LTCH PPS wage index for an urban area in the State with no wage data because it is based on pre-reclassified IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available. (Our rationale for using pre-reclassified IPPS wage data is discussed above in the beginning of this section.) As proposed, we are also establishing a policy for determining a LTCH PPS wage index value for rural areas with no IPPS wage data using the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State to serve as a reasonable proxy in determining the LTCH PPS wage index for a rural area without specific IPPS hospital wage index data. For this purpose, as proposed, we are defining "contiguous" as sharing a border. As explained, in the proposed rule, we are not able to apply an averaging in rural areas with no wage data similar to what we are doing for urban areas with no wage data because there is no rural hospital data available for averaging on a state-wide basis. We believe that using an unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State is a reasonable proxy for determining the wage index for rural areas in a State with no wage data because it is based on pre-reclassified IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available. (Our rationale for using pre-reclassified IPPS wage data is discussed above in the beginning of this section.) In addition, as IPPS wage data is dynamic, it is possible that areas without IPPS wage data may vary in the future, and each year we would determine a wage index value for any area in which there is no IPPS wage data

based on our methodologies. Additional details on our proposals on setting the LTCH PPS wage indices, which we are finalizing without modification in this final rule, are discussed below or can be found in the RY 2009 proposed rule (73 FR 5367).

Comment: We received no comments opposing and a few comments in support of our proposed methodology for setting LTCH PPS wage indices for areas where there are no IPPS wage data. These commenters noted that although it would be unlikely that a LTCH would operate in an area without an acute care IPPS hospital to supply wage data, as IPPS hospitals are a common referral source, the commenters agreed that it is practical to prepare for this unlikely scenario, and find our proposed methodology to be reasonable.

Response: We appreciate the commenters' support of our proposals to establish LTCH PPS wage index values for areas where there are no IPPS wage data. As noted above, currently, there are no LTCHs located in labor areas where there is no IPPS hospital wage data (or IPPS hospitals),however, we believe it is appropriate to establish a methodology for determining LTCH PPS wage index values for these areas in the event that in the future a LTCH should open in one of those areas. Thus, any LTCH that would open in area in which there is no IPPS wage data for which to compute a wage index based on our established methodology would have a wage index value assigned to them for determining their LTCH PPS payments.

In this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, we are finalizing our proposal to establish a policy for determining LTCH PPS wage index values for labor market areas in which there is no

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

The first situation for which we are establishing a policy for determining a LTCH PPS wage index value is for urban CBSAs with no IPPS wage data. Consistent with the policy established under other PPSs, such as the HHA (70 FR 40795 and 71 FR 65892 through 65893), as proposed, we are establishing a methodology of using an average of all of the urban areas within the State to serve as a reasonable proxy for determining the LTCH PPS wage index for an urban area without specific IPPS hospital wage index data. As we explained in the proposed rule, we believe that an average of all of the urban areas within the State would be a reasonable proxy for determining the LTCH PPS wage index for an urban area in the State with no wage data because it is based on pre-reclassified

IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available.

In this final rule, based on the FY 2004 IPPS wage data that we are using to determine the RY 2009 LTCH PPS wage index, which is discussed above, there is no IPPS wage data for the urban area of Hinesville-Fort Stewart, GA (CBSA 25980). (As we noted in the proposed rule, as IPPS wage data is dynamic, it is possible that urban areas without IPPS wage data will vary in the future.) Consistent with our policy for determining a LTCH PPS wage index value for urban areas with no IPPS wage data (discussed above), in this final rule, we calculated the wage index value for RY 2009 for CBSA 25980 as the average of the wage index values for all of the other urban areas within the State of Georgia (that is, CBSAs 10500, 12020, 12060, 12260, 15260, 16860, 17980, 19140, 23580, 31420, 40660, 42340, 46660 and 47580) (refer to Table 1 of the Addendum of this final rule). (As noted above, there are currently no LTCHs located in CBSA 25980). As discussed in the proposed rule, we believe that this policy could be readily applied to other urban CBSAs (besides CBSA 25980) that lack IPPS wage data. However, as proposed, we may re-examine the application of this policy should a similar situation arise in the future.

The other situation for which we are establishing a policy for determining a LTCH PPS wage index value is for rural areas with no IPPS wage data. Consistent with the policy established under other PPSs, such as the HHA (71 FR 65905 through 65906) and the IPPS (72 FR 47323 through 47324), as proposed, we are establishing a policy of using the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State to serve as a reasonable proxy in determining

the LTCH PPS wage index for a rural area without specific IPPS hospital wage index data. For this purpose, we define "contiguous" as sharing a border. As we explained in the proposed rule, we are not able to apply a similar averaging in rural areas with no wage data as we did above for urban areas with no wage data because there is no rural hospital data available for averaging on a state-wide basis. We believe that using an unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State is a reasonable proxy for determining the wage index for rural areas in a State with no wage data because it is based on pre-reclassified IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available.

In this final rule, based on the FY 2004 IPPS data that we are using to determine the RY 2009 LTCH PPS wage index, which is discussed above, rural Massachusetts (CBSA code 11) does not have any IPPS wage data. (As noted in the proposed rule, as IPPS wage data is dynamic, it is possible that rural areas without IPPS wage data will vary in the future.) Consistent with our policy for determining a LTCH PPS wage index value for rural areas with no IPPS hospital wage data (described above), in this final rule, we determined the wage index value for RY 2009 for rural Massachusetts by computing the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties in that State. Specifically, in the case of Massachusetts, the entire rural area consists of Dukes and Nantucket counties. As discussed in our proposal, we determined that the borders of Dukes and Nantucket counties are "contiguous" with Barnstable County, MA, and Bristol County, MA. Therefore, the RY 2009 LTCH PPS wage index value for rural Massachusetts is computed as the unweighted average of the

RY 2009 wage indexes for Barnstable county and Bristol county (refer to Tables 1 and 2 of the Addendum of this final rule). (As noted above, there are currently no LTCHs located in rural Massachusetts.) We discussed in the proposed rule, we believe that this policy could be readily applied to other rural areas (besides Massachusetts) that lack IPPS wage data (possibly due to acute-care hospitals converting to a different provider type that does not submit the appropriate wage data). However, we may re-examine the application of this policy should a similar situation arise in the future.

The RY 2009 LTCH wage index values that will be applicable for LTCH discharges occurring on or after July 1, 2008 through September 30, 2009, are presented in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum of this final rule. As discussed in greater detail above in section IV.B. of this preamble, we are moving the LTCH PPS annual payment rate update cycle from July 1 to October 1 and will have a 15-month rate year for 2009 (that is, July 1, 2008 through September 30, 2009). Therefore, as proposed, the next proposed update to the LTCH wage index values will be effective for discharges occurring on or after October 1, 2009 (FY 2010). In addition, as noted above, the wage index adjustment under the LTCH PPS was completely phased in beginning with cost reporting periods beginning in FY 2007 (that is, for cost reporting periods beginning on or after October 1, 2006). Therefore, for LTCH PPS discharges occurring during RY 2009, the labor related portion of the standard Federal rate is adjusted by the applicable full (five fifths) proposed RY 2009 LTCH PPS wage index value, which are shown in Tables 1 and 2 of the Addendum to this final rule).

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

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

Similarly, in the RY 2009 LTCH PPS proposed rule (73 FR 5368), under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, for RY 2009 we proposed to apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the proposed standard Federal payment rate by the proposed factors listed below in Table III because they were the most recent available data at that time. These proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and are currently also used under the IPPS (72 FR 47422). In addition, we proposed that if OPM releases revised COLA factors before March 1, 2008, we would use the revised factors for the development of LTCH PPS payments for RY 2009 and publish those revised COLA factors in the final rule.

We received no comments on our proposed COLA for LTCHs located in Alaska and Hawaii for RY 2009. We note that as of March 1, 2008, OPM did not revise the COLA factors we proposed for RY 2009 in the proposed rule. Accordingly, in this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, in this final rule, as proposed, we are establishing that for RY 2009 we will

make a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed below in Table III because they are the most recent available data at this time.

TABLE III: Cost-of-Living Adjustment Factors for Alaska and Hawaii Hospitals for the 2009 LTCH PPS Rate Year

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

3. Adjustment for High-Cost Outliers (HCOs)

a. Background

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

payments under the LTCH PPS are determined consistent with the instructions issued for the IPPS outlier policy.

Under §412.525(a) in the regulations (in conjunction with the revised definition of "LTC-DRG" at §412.503), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the MS-LTC-DRG plus a fixed-loss amount. Specifically, in accordance with §412.525(a)(3) (in conjunction with the revised definition of "LTC-DRG" at §412.503), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold, which is the sum of the adjusted Federal prospective payment for the MS-LTC-DRG and the fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under the outlier policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the LTCH PPS HCO policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage (currently 80 percent) of costs above the outlier threshold (MS-LTCDRG payment plus the fixed-loss amount). The fixed percentage of costs is called the marginal cost factor. We calculate the estimated cost of a case by multiplying the Medicare allowable covered charge by the overall hospital cost-to-charge ratio (CCR).

Under the LTCH PPS, we determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional payments. We calculate the fixed-loss amount by estimating aggregate payments with and without an outlier policy. The fixed-loss amount will result in estimated total outlier payments being projected to be

equal to 8 percent of projected total LTCH PPS payments. Currently, MedPAR claims data and CCRs based on data from the most recent provider specific file (PSF) (or from the applicable Statewide average CCR if a LTCH's CCR data are faulty or unavailable) are used to establish a fixed-loss threshold amount under the LTCH PPS.

b. Cost-to-Charge Ratios (CCRs)

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

In determining both HCO payments (at §412.525(a)) and SSO payments (at §412.529), we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. In general, we use the LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period, in accordance with §412.525(a)(4)(iv)(B) and §412.529(c)(4)(iv)(B) for HCOs and SSOs, respectively. (We note that in some instances we use an alternative CCR, such as the statewide average CCR in accordance with the regulations at §412.525(a)(4)(iv)(C) and §412.529(c)(4)(iv)(C), or a CCR that is specified by CMS or that is requested by the

hospital under the provisions of the regulations at §412.525(a)(4)(iv)(A) and §412.529(c)(4)(iv)(A).) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single "overall" or "total" LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100-4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (That is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

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

In the FY 2008 IPPS final rule with comment period, in accordance with §412.525(a)(4)(iv)(C)(2) for high-cost outliers and §412.529(c)(4)(iv)(C)(2) for short-stay outliers, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the March 2007 update to the Provider-

Specific File (PSF), we established a total CCR ceiling of 1.284 under the LTCH PPS effective October 1, 2007 through September 30, 2008. We also note that in the FY 2009 IPPS proposed rule (73 FR23681), using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the December 2007 update of the PSF, we proposed a total CCR ceiling of 1.262 under the LTCH PPS that would be effective October 1, 2008 through September 30, 2009. In that same proposed rule, we also proposed that if more recent data were available, we would use it to establish a total CCR ceiling under the LTCH PPS for FY 2009 in the FY 2009 IPPS final rule. (For further detail on our methodology for annually determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121) and the FY 2008 IPPS final rule with comment period (72 FR 47403 through 47404).)

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) since it is based on "total" IPPS CCR data. Under the LTCH PPS HCO policy at §412.525(a)(4)(iv)(C) and the SSO policy at §412.529(c)(4)(iv)(C), the fiscal intermediary (FI) may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (as discussed above); and (3) other LTCHs for whom

data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the FI may consider in determining a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In Table 8C of the Addendum the FY 2008 IPPS final rule with comment period (72 FR 48127), in accordance with the regulations at §412.525(a)(4)(iv)(C) for HCOs and §412.529(c)(4)(iv)(C) for SSO, using our established methodology for determining the LTCH statewide average CCRs, based on using the most recent complete IPPS total CCR data from the March 2007 update of the PSF, we established the LTCH PPS statewide average total CCRs for urban and rural hospitals effective for discharges occurring on or after October 1, 2007, and before October 1, 2008. We note that in the FY 2009 IPPS proposed rule (73 FR 23681), using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS total CCR data from the December 2007 update of the PSF, we proposed LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective for discharges occurring on or after October 1, 2008, and through September 30, 2009, in Table 8C of the Addendum to that proposed rule (73 FR 23874). In that same proposed rule, we also proposed that if more recent data were available, we would use it to establish LTCH PPS statewide average total CCRs for urban and rural hospitals for FY 2009 in the FY 2009 IPPS final rule. (For further detail on our methodology for annually determining the

LTCH urban and rural statewide average CCRs, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121) and FY 2008 IPPS final rule with comment period (72 FR 47403 through 47404).)

We note, under the LTCH PPS high cost outlier policy at §412.525(a)(4)(iv)(D) and the LTCH PPS SSO policy at §412.529(c)(4)(iv)(D), the payments for high cost outlier and SSO cases, respectively, are subject to reconciliation. Specifically, any reconciliation of outlier payments is based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. For additional information, refer to the RY 2008 LTCH PPS final rule (72 FR 26899 through 26900).

c. Establishment of the RY 2009 Fixed-Loss Amount

When we implemented the LTCH PPS, as discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56026), under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. To determine the fixed-loss amount, we estimate outlier payments and total LTCH PPS payments for each case using claims data from the MedPAR files. Specifically, to determine the outlier payment for each case, we estimate the cost of the case by multiplying the Medicare covered charges from the claim by the LTCH's hospital specific CCR. Under §412.525(a)(3) (in conjunction with the revised definition of "LTC-DRG" at §412.503), if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal prospective payment for the MS-LTC-DRG and the fixed-loss amount), we pay an outlier payment equal to 80 percent of

the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the MS-LTC-DRG and the fixed-loss amount).

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

We also discussed in the RY 2008 LTCH PPS rate year final rule (72 FR 26898), we calculated a single fixed-loss amount for the 2008 LTCH PPS rate year based on the version 24.0 of the GROUPER, which was the version in effect as of the beginning of the LTCH PPS rate year (that is, July 1, 2007 for the 2008 LTCH PPS rate year). In addition, we applied the outlier policy in the regulations at §412.525(a) in determining the fixed-loss amount for the 2008 LTCH PPS rate year; that is, we assigned the applicable Statewide average CCR only to LTCHs whose CCRs exceeded the ceiling. Accordingly, we used the FY 2007 LTCH PPS total CCR ceiling of 1.321 (72 FR 26898). As noted in that same final rule, in determining the fixed-loss amount for the 2008 LTCH PPS rate year using the CCRs from the PSF, there were no LTCHs with missing CCRs or with CCRs in excess of the current ceiling and, therefore, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs in

determining the fixed-loss amount for the 2008 LTCH PPS rate year (as this may have already been done by the FI in the PSF in accordance with the established policy).

Accordingly, in the RY 2008 final rule (72 FR 26898), as amended by the RY 2008 correction notice (72 FR 36613), we established a fixed-loss amount of $20,738 for the 2008 LTCH PPS rate year. In the recently issued interim final rule with comment that implements certain provisions of section 114 of the MMSEA, including the revision to the standard Federal rate for RY 2008, we revised the fixed-loss amount to $20,707 for discharges occurring on or after April 1, 2008 through June 30, 2008. Thus, we pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH PPS payment for the MS-LTC-DRG and the applicable RY 2008 fixed-loss amount).

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

Additionally, in the proposed rule, we used CCRs from the July 2007 update of the PSF for determining the proposed fixed-loss amount for the 2009 LTCH PPS rate year as they were the most recent complete available data at that time. Consistent with our historical practice of using the best data available, we also proposed that if more recent CCR data were available, we would use it for determining the fixed-loss amount for the 2009 LTCH PPS rate year in the final rule. Furthermore, in determining the proposed fixed-loss amount for the 2009 LTCH PPS rate year, we used the current FY 2008 applicable LTCH "total" CCR ceiling of 1.284 and LTCH Statewide average "total" CCRs established in the FY 2008 IPPS final rule (72 FR 47404 and 48126 through 48127) such that the current applicable Statewide average CCR would be assigned if, among other things, a LTCH's CCR exceeded the current ceiling (1.284).

Therefore, based on the data and policies described in the proposed rule, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, in this final rule, we are establishing a fixed-loss amount of $22,960 for the 2009 LTCH PPS rate year. Thus, we pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted proposed Federal LTCH payment for the MS-LTC-DRG and the fixed-loss amount of $22,960).

Comment: A few commenters expressed concern that we made an error in computing the proposed fixed-loss amount by not incorporating the changes to LTCH PPS payments provided for by the MMSEA, such as the modification to the payment formula for short-stay outlier (SSO) cases at §412.529 and to the payment adjustments to LTCH discharges that were admitted from specific referring hospitals and that exceed various percentage thresholds at §§412.534 and 412.536 (often referred to as the

"25-percent rule") that were current law. These commenters expected that because these MMSEA provisions would increase LTCH PPS payments in RY 2009, the fixed-loss amount for RY 2009 should either decrease from the current RY 2008 amount or be lower than the proposed fixed-loss amount (holding all other factors constant). The commenters believed that because total estimated RY 2009 LTCH PPS payments that include the effect of these MMSEA provisions would increase over the original estimate of RY 2009 LTCH PPS payments, the 8 percent outlier target that is based on total estimated payments would also increase in size, and therefore, the fixed-loss amount for RY 2009 should decrease in order to increase estimated high cost outlier payments so as to meet the 8 percent target. Several commenters also stated that they believe that, because we are projecting that estimated LTCH PPS payments would increase in RY 2009 as compared to RY 2008, the fixed-loss amount for RY 2009 should decrease relative to the RY 2008 fixed-loss amount. Therefore, these commenters recommended that the calculation of the fixed-loss amount for RY 2009 be revised to take into account all the known policy changes that would affect LTCH PPS payments in RY 2009, including those mandated by the MMSEA, as to not establish a fixed-loss amount that would result in "underpayment" to LTCHs. A few other commenters opposed the proposed increase to the fixed-loss amount since such an increase would result in fewer cases qualifying for an additional high cost outlier payment. One commenter remarked that the proposed "modest increase" in the fixed-loss amount is "acceptable," but asserted that LTCHs with very high case-mix indexes would be impacted more than LTCHs with low case-mix indexes. Another commenter stated that the proposed increase to the fixed-loss amount failed to consider the acuity of patients and is based only on mathematics.

The commenter added that the proposed increase to the fixed-loss amount would further increase LTCHs' loss on these cases before they qualify for an additional payment as HCOs. The commenter recommended that if CMS believes an increase to the fixed-loss amount is warranted, then any increase to the fixed-loss amount should be limited to an annual inflationary increase.

Response: We disagree with the commenters that we erred in the computation of the proposed fixed-loss amount by not incorporating all of the known policy changes that would affect LTCH PPS payments in RY 2009. In addition to including the proposed changes to the rates and factor for RY 2009 included in the proposed rule, such as the proposed 2.6 percent RY 2009 Federal rate, we did in-fact include those provisions of the MMSEA that would affect RY 2009 LTCH PPS payments. Specifically, our payment model for estimating RY 2009 LTCH PPS payments, used in both the proposed rule and in this final rule, incorporated the modification to the payment formula for SSO cases, such that in RY 2009 LTCH payments for SSO cases would be the lesser of 100 percent of the estimated cost of the case; 120 percent of the MS-LTC-DRG specific per diem amount for each covered day; the full LTC-DRG payment; or a blend of the 120 percent of the MS-LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount (capped at the full IPPS comparable amount). With respect to the "25-percent rule," historically in estimating LTCH PPS payments for purposes of determining the fixed-loss amount (and for the impact analysis, as we discuss in section XI. of this final rule), we have not included an estimated change in payments due to the payment adjustments to LTCH discharges that were admitted from specific referring hospitals and that exceed various percentage thresholds at §§412.534 and 412.536. We

are not aware of any instances where the FI has made any adjustments to LTCHs' payments under this policy. Consequently, we believe that LTCHs have modified their admission practices such that they have not become subject to those payment adjustments, and therefore, no estimated payment adjustments under these provisions are reflected in our payment model. Therefore, as the commenters recommended, in calculating both the proposed RY 2009 fixed-loss amount and the RY 2009 fixed-loss amount established in this final rule, we have taken into account all the known policy changes that would affect LTCH PPS payments in RY 2009, including those mandated by the MMSEA.

Generally, we would agree with the commenters that an estimated increase in LTCH PPS payments alone, holding all other factors constant, should result in a decrease in the fixed-loss amount from the current fixed-loss amount. However, the commenters have not considered other factors that affect the computation of the fixed-loss amount. Specifically, as discussed in the proposed rule and as discussed below in this section, we used the best available LTCH claims data from the MedPAR files and CCRs from the PSF to estimate total LTCH PPS payments and to estimate the costs of each case, as well as the payment rates, factors and policies that would be in effect during the applicable time period, in determining a fixed-loss amount that would result in estimated outlier payments that would be equal to 8 percent of total estimated payments. In computing the current fixed-loss amount for RY 2008, as noted above, we used claims data from the December 2006 update of the FY 2006 MedPAR files and CCRs from the December 2006 update of the PSF, as that was the best available data at that time. We also used Version 24.0 (FY 2007) of the GROUPER software and the FY 2007

LTC-DRG relative weights to determine the RY 2008 fixed-loss amount as this was the version that was in effect as of the beginning of RY 2008 (July 1, 2007). In the proposed rule, in computing the proposed fixed-loss amount for RY 2009 that would result in estimated outlier payments that would be equal to 8 percent of total estimated payments, we used LTCH claims data from the March 2006 update of the FY 2006 MedPAR files and CCRs from the July 2007 update of the PSF as they were the most recent complete available data at that time. We also used Version 25.0 (FY 2008) of the GROUPER software and the FY 2008 MS-LTC-DRG relative weights to determine the proposed RY 2009 fixed-loss amount as this would be the version that would be in effect as of the beginning of RY 2009 (July 1, 2008). As we have discussed throughout this section, in order to determine a fixed-loss amount that would result in estimated high cost outlier payments that would be equal to 8 percent of total estimated payments, it is necessary to use the best available payment rates, factors and policy information upon which to compute those payment estimates, and therefore, it would be inappropriate to "hold all other factors constant" when determining the fixed-loss amount. Furthermore, based on the most recent available data and payment model described above, we currently project that estimated RY 2008 high cost outlier payments are approximately 8.2 percent of estimated total RY 2008 LTCH PPS payments. Maintaining the fixed-loss amount at the current level would result in HCO payment that exceed the current regulatory requirement that estimated HCO payments would be projected to equal 8 percent of estimated total LTCH PPS payments. Therefore, based on more recent data, it appears that the current RY 2008 fixed-loss amount may be too low since estimated HCO payments are slightly higher than the 8 percent target. For these reasons, we disagree

with commenters that just because we are projecting an estimated increase in LTCH PPS payments in RY 2009 as compared to RY 2008, the fixed-loss amount for RY 2009 should decrease relative to the RY 2008 fixed-loss amount or should be lower than the proposed RY 2009 fixed-loss amount.

We acknowledge that an increase to the fixed-loss amount will increase a LTCH's "loss" on a specific case before it qualifies for an additional payment a HCO, as noted by one commenter; however, as we explained in the RY 2007 LTCH PPS final rule (71 FR 27836), because a relatively higher fixed-loss amount identifies fewer cases as HCO cases (since the amount that the estimated cost of the case must exceed before the case qualifies as a HCO case is higher), such a policy better identifies LTCH patients that are unusually costly cases. The intent of the HCO policy is to provide an additional payment to LTCH cases that have unusually high costs. We would remind commenters that if we would not increase the fixed-loss amount, HCO payments would represent significantly more than 8 percent of estimated total LTCH PPS payments. Furthermore, as also discussed in the same RY 2007 final rule, HCO payments are budget neutral and are funded by prospectively reducing the non-outlier PPS payment rates by projected total outlier payments. The higher the outlier target, the greater the (prospective) reduction to the base payment that would need to be applied to the standard Federal rate in order to maintain budget neutrality. Moreover in the proposed rule (73 FR 5371), we discussed the possibility of adjusting the existing 8 percent outlier target or 80 percent marginal cost factor under the LTCH PPS HCO policy and explained our reasons for not proposing to make any changes to those components of the LTCH PPS HCO policy at that time. However, we stated that we continue to be interested in any comments that

would support revisiting the analysis that was used to establish the existing 8 percent outlier target and the existing 80 percent marginal cost factor, using the most recent available data to evaluate whether any changes to the current HCO policy should be made, and therefore, may result in a smaller increase (or even a decrease) in the fixed-loss amount for RY 2009. We received no comments in response to this solicitation or in response to our decision not to propose changes to the existing 8 percent outlier target and the existing 80 percent marginal cost factor. Therefore, for the reasons cited previously in this response, we continue to believe that it is appropriate to increase the fixed-loss amount in order to maintain estimated HCO payments at the projected 8 percent of total estimated payments. Such a policy continues to appropriately identify cases that are HCO cases (that is, cases with an unusually high cost). Because maintaining an 8 percent outlier target necessitates an increase to the fixed-loss amount based on our payment simulations, we are not adopting the commenter's suggestion to limit any increase to the fixed-loss to an annual inflationary increase, such as the most recent estimate of the LTCH PPS market basket because that would result in estimated outlier payments in excess of 8 percent of estimated total LTCH PPS payments.

We appreciate the commenters' acceptance of the proposed increase to the fixed-loss amount; however, we disagree that the increase would have a disproportionate impact on LTCHs with very high case-mix indexes as compared to LTCHs with low case-mix indexes. Rather we believe that LTCHs with high and low case mix indexes would be impacted similarly by the change in the fixed loss amount. High cost outlier payments are made to LTCHs when the estimated costs of a case exceed the adjusted MS-LTC-DRG payment amount by more than the fixed-loss amount, with the additional

outlier payment equaling 80 percent of that difference as provided in §412.525(a) (in conjunction with §412.503). Cases in MS-LTC-DRGs with higher relative weights (higher case-mix) receive higher adjusted MS-LTC-DRG payments than cases in MS-LTC-DRGs with lower relative weights (lower case-mix). With differences in case-mix already accounted for in the adjusted MS-LTC-DRG payment amounts that are part of the formula for determining high cost outlier payments, LTCHs with higher or lower case-mix are treated similarly in terms of how much costs must exceed the adjusted MS-LTC-DRG payment amount by in order to receive additional high cost outlier payments. In addition, as we discussed in the RY 2007 final rule (71 FR 27835), LTCHs could have a relatively high case-mix index, but have few or no HCO cases since a "high" case-mix index is an indication of the level of intensity of the types of patients treated at a LTCH and not necessarily an indication of treating unusually high cost cases.

In summary, we believe that an increase to the fixed-loss amount for RY 2009 is appropriate. We are using the same methodology that we proposed to use in the RY 2009 proposed rule to calculate the fixed-loss amount for RY 2009 in this final rule (using updated data and the policies established in this final rule, as described below) in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Consistent with our historical practice of using the best data available as we proposed, in this final rule, in determining the fixed-loss amount for RY 2009, we used the most recent available LTCH claims data and CCR data, as well as all the known policy changes that would affect LTCH PPS payments in RY 2009, including those mandated by the MMSEA and those established in this final rule. Specifically, in this final rule, for the 2009 LTCH PPS rate year, we used LTCH claims data from the

December 2007 update of the FY 2007 MedPAR files to determine a fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments in RY 2009, based on the policies described in this final rule (including those established in section 114 of the MMSEA as discussed above), because these data are the most recent complete LTCH data currently available. As noted above, as proposed, we determined the RY 2009 fixed-loss amount based on the version of the GROUPER that will be in effect as of the beginning of the 2009 LTCH PPS rate year (July 1, 2008), that is, Version 25.0 of the GROUPER (as established in the FY 2008 IPPS final rule (72 FR 47278)). Additionally, in this final rule, we used CCRs from the January 2008 update of the PSF for determining the RY 2009 fixed-loss amount as they are the most recent complete data currently available. Furthermore, as proposed, in determining the RY 2009 fixed-loss amount, we used the current FY 2008 applicable LTCH "total" CCR ceiling of 1.284 and LTCH Statewide average "total" CCRs established in the FY 2008 IPPS final rule (72 FR 47404 and 48126 through 48127) such that the current applicable Statewide average CCR would be assigned if, among other things, a LTCH's CCR exceeded the current ceiling (1.284). As was the case when we determined the proposed RY 2009 fixed-loss amount in the proposed rule, in determining the RY 2009 fixed-loss amount using the CCRs from the PSF, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs (as this may have already been done by the FI or MAC in the PSF in accordance with our established policy). (Currently, the applicable FY 2008 LTCH Statewide average CCRs can be found in Table 8C of the FY 2008 IPPS final rule (72 FR 48126 through 48127).)

In this final rule, based on the data and policies described in this final rule (including those established in section 114 of the MMSEA as discussed above), under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are establishing a fixed-loss amount of $22,960 for the 2009 LTCH PPS rate year. Thus, we will to pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the MS-LTC-DRG and the fixed-loss amount of $22,960).

We note that the final fixed-loss amount for RY 2009 is somewhat higher than the proposed RY 2009 fixed-loss amount of $21,199 and the current fixed-loss amount of $20,738. As discussed in greater detail above, based on the most recent available LTCH data to estimate the cost of each LTCH case and estimated total LTCH PPS payments, this increase in the fixed-loss amount is appropriate and necessary to maintain the requirement that estimated outlier payments would be projected to be equal to 8 percent of estimated total LTCH PPS payments, as required under §412.525(a). As stated above, based on the most recent available data we estimate that the current fixed-loss amount may be too low as our payment models project that RY 2008 HCO payments are estimated to equal 8.2 percent of total estimated LTCH PPS payments. As we discussed in the proposed rule (73 FR 5371), maintaining the fixed-loss amount at the current level would result in HCO payments above the current regulatory requirement that estimated outlier payments would be projected to equal 8 percent of estimated total LTCH PPS payments. Based on the regression analysis that was performed when we implemented the LTCH PPS (August 30, 2002 final rule (67 FR 56022 through 56027)), we established the outlier target at 8 percent of estimated total LTCH PPS payments to allow

us to achieve a balance between the "conflicting considerations of the need to protect hospitals with costly cases, while maintaining incentives to improve overall efficiency" (67 FR 56024). That regression analysis also showed that additional increments of outlier payments over 8 percent (that is, raising the outlier target to a larger percentage than 8 percent) would reduce financial risk, but by successively smaller amounts. Outlier payments are budget neutral, and therefore, outlier payments are funded by prospectively reducing the non-outlier PPS payment rates by projected total outlier payments. The higher the outlier target, the greater the (prospective) reduction to the base payment would need to be applied to the Federal rate to maintain budget neutrality.

As an alternative to proposing to lower the fixed-loss amount for RY 2009, in the proposed rule (73 FR 5371), we discussed adjusting the marginal cost factor (that is, the percentage that Medicare will pay of the estimated cost of a case that exceeds the sum of the adjusted Federal prospective payment for the MS-LTC-DRG and the fixed-loss amount for LTCH PPS outlier cases as specified in §412.525(a)(3) (in conjunction with the revised definition of "LTC-DRG" at §412.503), which is currently equal to 80 percent, as a means of ensuring that estimated outlier payments would be projected to equal 8 percent of estimated total LTCH PPS payments. When we initially established the 80 percent marginal cost factor in the August 30, 2002 final rule (67 FR 56022 through 56027), we explained that our analysis of payment-to-cost ratios for HCO cases showed that a marginal cost factor of 80 percent appropriately addresses outlier cases that are significantly more expensive than nonoutlier cases, while simultaneously maintaining the integrity of the LTCH PPS.

In proposing increases to the fixed-loss amount for RY 2007, RY 2008 and RY 2009 (71 FR 27834; 72 FR 4799 through 4800; and 73 FR 5371, respectively), we solicited comments on whether we should revisit the regression analysis discussed above in this section that was used to establish the existing 8 percent outlier target and 80 percent marginal cost factor, using the most recent available data to evaluate whether the current outlier target of 8 percent or the 80 percent marginal cost factor should be adjusted, and therefore, could have resulted in less of an increase in the fixed-loss amount for RY 2007 and RY 2008, respectively. In response to this solicitation in the RY 2007 proposed rule (as summarized in the RY 2007 LTCH PPS final rule (71 FR 27834 through 27835)), several commenters opposed any option that would allow us to revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent. The commenters stated their belief that the LTCH PPS is still in its early stages and further changes to the 80 percent marginal cost factor or 8 percent outlier target would result in instability to the system. The commenters cautioned against making any premature changes to the factors affecting HCO payments to LTCHs, particularly the marginal cost factor and outlier target established by regulation when the LTCH PPS was implemented. Also, the commenters agreed that keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent better identifies LTCH patients that are unusually costly cases, and that this policy appropriately addresses outlier cases that are significantly more expensive than non-outlier cases. Similarly, as summarized in the RY 2008 final rule (72 FR 26897 through 26899), we received no comments in support of revisiting the regression analysis discussed above that was used to establish the existing 8 percent outlier target and

80 percent marginal cost factor, using the most recent available data to evaluate whether the current outlier target of 8 percent or the 80 percent marginal cost factor should be adjusted in response to our solicitation on this issue. As noted above, we received no response to this solicitation in the RY 2009 proposed rule.

In response to these comments, we agreed with the commenters that, based on the regression analysis done for the implementation of the LTCH PPS (August 30, 2002; 68 FR 56022 through 56027), a marginal cost factor of 80 percent and a outlier target of 8 percent adequately identifies LTCH patients that are unusually costly cases, and that such a policy appropriately addresses LTCH HCO cases that are significantly more expensive than non-outlier cases, which is consistent with our intent of the LTCH HCO policy as stated when we implemented the LTCH PPS in the August 30, 2002 final rule (67 FR 56025). Therefore, as supported by many commenters, in both the RY 2007 final rule (71 FR 27834) and the RY 2008 final rule (72 FR 26897 through 26899), we did not revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent, and therefore, did not make any changes to the marginal cost factor or outlier target in either of those final rules.

Although increasing the fixed-loss amount from $20,738 to $22,960 based on the latest available data and all known policy changes that would affect LTCH PPS payments in RY 2009, including those mandated by the MMSEA and those established in this final rule, will increase the amount of the "loss" that a LTCH must incur under the LTCH PPS for a case with unusually high costs before the LTCH would receive any additional Medicare payments, as we discussed above and as we explained in greater detail in the RY 2006 LTCH PPS final rule (70 FR 24195 through 24196), we continue to believe that

the existing 8 percent outlier target and 80 percent marginal cost factor continue to adequately maintain the LTCHs' share of the financial risk in treating the most costly patients and ensure the efficient delivery of services. Accordingly, we are not adjusting the existing 8 percent outlier target or 80 percent marginal cost factor under the LTCH PPS HCO policy at this time.

For the reasons described above, we believe the final fixed-loss amount of $22,960 will appropriately identify unusually costly LTCH cases while maintaining the integrity of the LTCH PPS. Therefore, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are establishing a fixed-loss amount of $22,960 based on the best available LTCH data and all of the known policy changes that would affect LTCH PPS payments in RY 2009, including those mandated by the MMSEA and those established in this final rule, because we believe an increase in the fixed-loss amount is appropriate and necessary to maintain estimated outlier payments are projected to be equal to 8 percent of estimated total LTCH PPS payments, as required under §412.525(a).

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

As we discussed in the August 30, 2002 final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a SSO case (as defined in the regulations at §412.529 in conjunction with the regulations at §412.503 and discussed in section IV.G. of this preamble) and also as a HCO case. In this scenario, a patient could be hospitalized for less than five-sixths of the geometric ALOS for the specific MS-LTC-DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the high cost outlier threshold (that is, the SSO payment plus the fixed-loss amount), the

discharge is eligible for payment as a HCO. Thus, for a SSO case in the 2009 LTCH PPS rate year, the HCO payment would be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed fixed-loss amount of $22,960 and the amount paid under the SSO policy as specified in §412.529).

4. Other Payment Adjustments

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

In the August 30, 2002 LTCH PPS final rule, we detailed the extensive data analysis performed by our contractor, 3M Health Information Systems (3M) and our resulting decisions to implement a COLA for LTCHs in Alaska and Hawaii (§412.525(b)) and an adjustment to account for geographical differences in area wage levels (§412.525(c)). In addition, we discussed the extensive data analyses that led to the decision not to implement adjustments for geographic reclassification, rural location, the treatment of a disproportionate share of low-income patients (DSH), or indirect medical

education (IME) costs. We also noted that we would continue to collect data and revisit these determinations as additional data became available. (For more detailed information, see 67 FR 56014 through 56027.)

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

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

Therefore, in the RY 2009 LTCH PPS proposed rule, we indicated that we had 3M perform data analyses similar to those conducted at the inception of the LTCH PPS for FY 2003. 3M evaluated LTCH data from the most recent cost report files in our HCRIS database (updated through June 30, 2007) for providers' cost reports beginning during fiscal years 2004 through 2006 (73 FR 5371 through 5372). At that time, we stated that we believe that in the 5 years since the start of the LTCH PPS, there has been

sufficient new data generated to allow for a comprehensive reevaluation the appropriateness of payment adjustments such as geographic reclassification, rural location, DSH, and IME under the LTCH PPS at this time.

In the RY 2009 LTCH PPS proposed rule, we stated that our most recent data analysis which is based on the comprehensive data analysis by 3M (referenced above), indicates that proposing payment adjustments for geographic reclassification, rural location, DSH, or indirect medical education (IME) costs would not improve the accuracy of payments to LTCHs (73 FR 3772). (3M's "Report on LTCH Payment Methodology Review and Results" is posted on our Web site at http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopOfPage. We also noted that we believed that these analyses confirm our initial determinations as we developed the LTCH PPS regarding the applicability of PPS payment adjustments. Therefore, we did not propose to adopt any additional payment adjustments such as geographic reclassification, rural location, DSH, or IME, as features of the LTCH PPS. Finalized policies for the RY 2009 wage index adjustment and the COLA were discussed in sections IV.D.1 and 2. of this final rule, respectively. Furthermore, now that the 5-year transition to the LTCH PPS was completed, we noted that we had collected data that reflects LTCH behavior in response to the implementation of the LTCH PPS. We believe that our above described analyses of LTCH PPS data do not support the adoption of any additional payment adjustments. We further stated that we believe that since 3M's recent analyses confirm policy determinations that had been in place since the implementation of the LTCH PPS for FY 2003, that annual data analyses related to potential payment adjustments for geographic reclassification, rural location, DSH or IME would not be

necessary barring significant transformations in the nature of the LTCH universe or substantial changes in Medicare payment outcomes that warrant additional evaluation.

Comment: One commenter requested that we consider applying a payment adjustment under the LTCH PPS to account for increased provider costs at LTCHs for dialysis patients. Specifically, the commenter suggested that we adopt the IPPS policy of providing additional payments to LTCHs if 10 percent or more of the hospital's annual Medicare discharges are dialysis patients. Alternatively, the commenter suggested that a new MS-DRG be added to recognize the increase in LTCH resources utilized by a patient requiring dialysis. The commenter also states that Medicare payments presently do not take into account resources used for providing higher intensity wound care that does not require surgical intervention. The commenter suggests that Medicare undertake a study to determine whether the MS-DRG system captures the resource intensity necessary for treating this group of patients.

Response: When we were designing the payment system for LTCHs, we evaluated the policies and payment adjustments that are features of the PPS for inpatient acute care hospitals (IPPS) and our contractor, 3M Health Information Systems conducted comprehensive analyses of CMS data to determine which elements were appropriate for adoption in the projected LTCH PPS. It was apparent from these analyses that even though LTCHs are certified as acute care hospitals and further, that in many communities, patients that could otherwise be treated in LTCHs are treated in acute care hospitals as high cost outliers, that there are differences between the hospitals systems that should result in different payment features,. One of these features was the ESRD payment add-on. Under the IPPS, additional payments are made for patients with ESRD

who receive dialysis treatment during an inpatient hospital stay unless the principal diagnosis (which determines the Major Diagnostic Category to which a case is assigned) is one of three diagnosis-related groups (MS-DRGs) directly related to kidney disease. An IPPS hospital is eligible for the additional payment if ESRD beneficiaries, excluding discharges classified into the three MS-DRGs directly related to kidney disease, constitute at least 10 percent of the hospital's total Medicare discharges. Furthermore, in order for such a case to count towards the threshold percentage, the patient must be certified end stage renal dialysis (ESRD) patient, that is, the patient must have applied and been approved for this program. (The specifics of this payment adjustment are set forth at §412.104) The reason for this is that the number of patients requiring ESRD treatment in all of the acute care hospitals in the country over the course of any year (other than in those three MS-DRGs referenced above), represent a small fraction of acute care hospital cases. Therefore, the costs for treating that small number of cases would not be substantially reflected in the averaging methodology that we use to determine the relative payment for each MS-DRG. If an acute care hospital, for example, treats a patient with a broken leg, who also needs dialysis, costs of the dialysis treatment for that patient would not have a significant impact on the averaging process of costs for all broken leg cases nationwide, and would not be factored into the DRG payment for that case to that acute care hospital. We have established the ESRD add-on because we believed that if more than 10 percent of such a hospital's discharges during a cost reporting period presented such a scenario, this additional payment would ensure that the acute care hospital was adequately compensated by Medicare for providing total medial treatment for such patients.

In response to the commenter's suggestion that we adopt a similar policy under the LTCH PPS, we continue to believe that applying this payment adjustment to LTCHs would be inappropriate. LTCH's typically treat very sick patients with a number of serious secondary illnesses (multicomorbidities) that require hospital-level care for, on average, greater than 25 days for any one spell of illness. We believe that given the patient population treated at LTCHs, a higher proportion of LTCH patients would require dialysis than would be treated at an acute care hospital and paid for under the IPPS. Although the LTCH PPS uses the same patient classification system as is used by the IPPS, the relative weights assigned to the MS-LTC-DRGs under the LTCH PPS, are based on LTCH cases which reflect "differences in patient resource use and costs," in LTCHs as mandated by the Balanced Budget Refinement Act (BBRA) of 1999, the initial enabling statute for the establishment of the LTCH PPS. A patient-classification system using relative weights, such as the DRG-based system used by both the IPPS and the LTCH PPS, determines the amount that Medicare pays for particular types of cases, based on the hospital resources employed in treating such cases as compared to the resources utilized in treating other types of cases and assigns all cases numerical values, called "relative weights". Data, such as charges, used to measure hospital resource use for each MS-LTC-DRG are captured on patient claims which Medicare uses in the annual update of the relative weights. Accordingly, we believe that the additional resources associated with renal dialysis treatments are include in the data used to set the MS-LTC-DRG relative weights each year.

The BBRA also required that total estimated payments under the LTCH PPS, established at the outset of the LTCH PPS for cost reporting periods beginning on or after

October 1, 2002, was to be budget neutral to what Medicare would have paid under the then-existing reasonable-cost based TEFRA payment system had the LTCH PPS not been implemented. All patient treatment costs reflected in the LTCH cost data under the TEFRA payment system were included in our calculation of the base standard Federal rate that was established for FY 2003. Since FY2003, the standard Federal Rate has been updated annually (48 FR 39746 and 67 FR 55957). Accordingly, we believe that since renal dialysis treatments were among treatments offered at LTCHs prior to the beginning of the LTCH PPS (for cost reporting periods beginning on or after October 1, 2002), that the costs of such treatments would have been included in the base standard Federal rate, which is the foundation of the current standard Federal rate (and the RY 2009 standard Federal rate).

Given the typical profile of the Medicare beneficiary receiving treatment in LTCHs, dialysis is not an uncommon treatment so we believe that the costs associated with ESRD as a secondary diagnoses or comorbidity are both reflected in the setting of the standard Federal payment rate and also are reasonably reflected in the annual update of the MS-LTC-DRG weights based on the resources used in treating cases that are grouped into specific MS-LTC-DRGs (see 67 FR 55984 through 55995 and 72 FR 47277). Therefore, we believe our payments for specific cases under the LTCH PPS include the higher costs associated with dialysis treatments for patients in LTCHs without any additional add-on. Furthermore, an additional feature of the LTCH PPS is that Medicare will make outlier payments for unusually costly patients, including those with ESRD, if the costs for treating any patient exceed a specified threshold.

Consequently, at this time, we do not believe that an additional ESRD adjustment is either appropriate or necessary under the LTCH PPS.

The commenters alternatively suggested the addition of an additional MS-DRG that would recognize the higher resource use of dialysis patients. When we developed the MS-DRGs for use beginning October 1, 2007, we reduced the existing CMS DRGs down to the base DRGs, then applied the five specific criteria upon which we would evaluate the instances under which we would then subdivide those base DRGs into subgroups based on the severity of the cases. Therefore, this alternative had already been considered and rejected, as the base DRG did not meet all of the criteria required to make additional subgroups. These criteria are listed in the FY 2008 IPPS final rule (72 FR 47169). Therefore, we will not create additional MS-LTC-DRGs reflecting dialysis treatments for FY 2009.

Regarding the commenter's concern that Medicare does not recognize the hospital resources utilized in treating higher intensity wounds not requiring surgery, we note that Medicare payments are based on data gathered from LTCH cost reports and LTCH Medicare claims and we believe, therefore, that the LTCH PPS payments which are based upon this data reflect the reported resource use (that is, charges and costs) of delivering care to Medicare beneficiaries at LTCHs including treatment for higher intensity wounds not requiring surgery. However, we also note that MS-LTC-DRG system is not static but is rather a dynamic mechanism which is responsive to changes in medical resource use. If, for example, new and more costly treatment modalities became available for a particular MS-LTC-DRG, that result in increased hospital costs, such increased costs would eventually be reflected in increased MS-LTC-DRG relative

weights in the future (typically there is about a 2-year lag in the claims data used to set the relative weights). Similarly, should treatment modalities result in decreased treatment costs, we would expect the relative weights for those MS-LTC-DRGs affected by this change to decrease. Additionally, as noted above, we would also remind the commenter that under the LTCH PPS, if the costs for treating any patient exceed a specified threshold the case could qualify for high cost outlier payments. For the same reasons noted previously in this paragraph, we also believe it is unnecessary to undertake a study on such wound patients.

We would also remind the commenter that Medicare payment under a PPS is based on a system of averages, so that some Medicare payments may exceed hospital costs for a particular case which would then offset other cases where the Medicare payments were less than the hospital costs. With this model in mind, and available data on LTCH costs and industry margins and growth since the start of the LTCH PPS for cost reporting periods beginning on or after October 1, 2002, we believe that, in general, our Medicare payment policies under the LTCH PPS have been and continue to be appropriate and reasonable.

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

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs be budget neutral for the initial year of implementation. Furthermore, under section 307(a)(2) of the BIPA, the increases to the target amounts and the cap on the target amounts for LTCHs provided for by section 307(a)(1) of BIPA (as set forth in section 1886(b)(3)(J) of the Act), and the enhanced bonus payments for LTCHs provided for by section 122 of BBRA (as set forth in section 1886(b)(2)(E) of the Act) were not to

be taken into account in the development and implementation of the LTCH PPS. Therefore, when we implemented the LTCH PPS, in the August 30, 2002 final rule (67 FR 56052), we established a budget neutrality requirement at §412.523(d)(2) for calculating the standard Federal rate for FY 2003 such that estimated aggregate LTCH PPS payments were estimated to be equal to estimated payments that would have been made to LTCHs under the reasonable cost-based payment methodology had the PPS for LTCHs not been implemented, and, to implement section 307(a)(2) of the BIPA, we excluded the effects of sections 1886(b)(2) and (b)(3) of the Act.

We proposed a technical correction to existing §412.523(d)(2) that would more precisely describe the provisions of sections 1886(b)(2) and (b)(3) of the Act that were not taken into account when determining the standard Federal rate under §412.523(d). The current regulatory language at §412.523(d)(2) cites the general sections of the Act which contain the specific provisions set forth in §307(a)(2) of Pub. L. 106-554 that the Secretary is required to not take into account in developing the PPS. We believe that it is clearer and more precise to cite the specific subparagraphs the Secretary did not take into account rather than to cite the general sections of the Act of which such subparagraphs are a part. In order to mitigate any confusion that may be caused by existing regulations, we proposed to make a technical correction at §412.523(d)(2). Specifically, we proposed to revise §412.523(d)(2) to state that the effects of section 1886(b)(2)(E) of the Act (enhanced bonus payments for LTCHs, as described above) and section 1886(b)(3)(J) of the Act (increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs, as described above) were excluded in the development of the FY 2003 LTCH PPS standard Federal rate. This technical correction would make the

regulatory language consistent with section 307(a)(2) of BBRA and consistent with the methodology we used to determine the LTCH PPS standard Federal rate under §412.523, and it is not a change in policy. (Accordingly, no adjustments to the LTCH PPS standard Federal rate computed under §412.523(d) were proposed in conjunction with this proposed technical correction to §412.523(d)(2).)

We received no comments on this proposed technical correction. Therefore, for the reasons described above, in this final rule, as we proposed, we are revising §412.523(d)(2) to state that the effects of section 1886(b)(2)(E) of the Act (enhanced bonus payments for LTCHs) and section 1886(b)(3)(J) of the Act (increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs) were excluded in the development of the FY 2003 LTCH PPS standard Federal rate.

G. Conforming Changes

Various regulations throughout 42 CFR Part 412 Subpart O indicate that the terms "urban area" and "rural area" are defined according to the definitions of "urban area" and "rural area" found in 42 CFR Part 412 Subpart D (the IPPS regulations). Specifically, §§412.525(c), 412.529(d)(4)(ii)(B) and (d)(4)(iii)(B), 412.534(d)(1), (f)(2)(ii), and (f)(3)(ii), and 412.536(c)(1), (e)(2)(ii), and (e)(3)(ii) of Subpart O refer to the definitions of "urban area" and "rural area" in either §412.62(f)(1)(ii) and (f)(1)(iii) or §412.64(b)(1)(ii)(A)-(C) in 42 CFR Part 412 Subpart D. As discussed above in section IV.F.1.b.(4). of this preamble, we believe that it is administratively simpler to define the terms "urban area" and "rural area" in §412.503 rather than cross-referencing the definitions of "urban area" and "rural area" in §412.62(f)(1)(ii) and §412.62(f)(1)(iii) and §412.64(b)(1)(ii)(A) through (C). Consequently, as we proposed, we are adding

definitions for "urban area" and "rural area" in §412.503 which will incorporate the provisions of §412.62(f)(1)(ii) and (f)(1)(iii) as well as §412.64(b)(1)(ii)(A) through (C). In the proposed rule (73 FR 5372), because we proposed to define "urban area" and "rural area" in §412.503, we proposed to replace the citations to the definitions of "urban area" and "rural area" at §412.62(f)(1)(ii) and §412.62 (f)(1)(iii) and §412.64(b)(1)(ii)(A) through (C) which are found in the existing regulations at §§412.525(c), 412.529(d)(4)(ii)(B) and (d)(4)(iii)(B), 412.534(d)(1), (f)(2)(ii), and (f)(3)(ii), and 412.536(c)(1), (e)(2)(ii), and (e)(3)(ii) with references to §412.503.

We received no comments on this proposed conforming change. Accordingly, in this final rule, as proposed, we are revising the above-described references. Specifically, we are replacing the citations to the definitions of "urban area" and "rural area" at §412.62(f)(1)(ii) and §412.62 (f)(1)(iii) and §412.64(b)(1)(ii)(A)-(C) in the existing regulations at §§412.525(c), 412.529(d)(4)(ii)(B) and (d)(4)(iii)(B), 412.534(d)(1), (f)(2)(ii), and (f)(3)(ii), and 412.536(c)(1), (e)(2)(ii), and (e)(3)(ii) with references to §412.503.

V. Computing the Adjusted Federal Prospective Payments for the 2009 LTCH PPS Rate Year

In accordance with §412.525 and as discussed in section IV.F.1. of this final rule, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 1 and 2 of the Addendum of this final rule). The standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate

by the appropriate cost-of-living factor (shown in Table III in section IV.F.2 of this preamble). In this final rule, we are establishing a standard Federal rate for the 2009 LTCH PPS rate year of $39,114.36 as discussed in section IV.E.2. of this preamble. We illustrate the methodology to adjust the Federal prospective payments for the 2009 LTCH PPS rate year in the following example:

Example:

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

To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted Federal prospective payment amount by multiplying the unadjusted standard Federal rate ($39,114.36) by the labor-related share (75.662 percent) and the wage index value (1.0715). This wage-adjusted amount is then added to the nonlabor-related portion of the unadjusted standard Federal rate (24.338 percent; adjusted for cost of living, if applicable) to determine the adjusted Federal rate, which is then multiplied by the MS-LTC-DRG relative weight (1.1417) to calculate the total adjusted Federal prospective payment for the 2009 LTCH PPS rate year ($47,072.73). Table IV illustrates the components of the calculations in this example.

TABLE IV:

Unadjusted Standard Federal Prospective Payment Rate	$39,114.36
Labor-Related Share	x 0.75662
Labor-Related Portion of the Federal Rate	= $29,594.71
Wage Index (CBSA 16974)	x 1.0715
Wage-Adjusted Labor Share of Federal Rate	= $31,710.73
Nonlabor-Related Portion of the Federal Rate ($39,114.36 x 0.24338)	+ $ 9,519.65
Adjusted Federal Rate Amount	= $41,230.38
MS-LTC-DRG 9 Relative Weight	x 1.1417
Total Adjusted Federal Prospective Payment	= $47,072.73

VI. Monitoring

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

In the RY 2009 proposed rule, we summarized policy initiatives that we have issued as a result of our ongoing monitoring program (73 FR 5373 through 5374).

We did not propose any new payment adjustments in the RY 2009 proposed rule resulting from our monitoring activity, but we continue to pursue our ongoing monitoring program that involves the CMS Office of Research and Development (ORDI), existing

QIO monitoring, monitoring by Medicare contractors (that is, FIs or MACs), and studies described in the RY 2006 LTCH PPS final rule (70 FR 24211).

VII. Method of Payment

Under §412.513, a Medicare LTCH patient is classified into a MS-LTC-DRG based on the principal diagnosis, up to eight additional (secondary) diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The MS-LTC-DRG is used to determine the Federal prospective payment that the LTCH will receive for the Medicare-covered Part A services the LTCH furnished during the Medicare patient's stay. Under §412.541(a), the payment is based on the submission of the discharge bill. The discharge bill also provides data to allow for reclassifying the stay from payment at the full MS-LTC-DRG rate to payment for a case as a SSO (under §412.529) or as an interrupted stay (under §412.531), or to determine if the case will qualify for a HCO payment (under §412.525(a)).

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

As under the previous reasonable cost-based payment system, under §412.541(b), a LTCH may elect to be paid using the periodic interim payment (PIP) method described in §413.64(h), based on the estimated prospective payment for the year, and may be eligible to receive accelerated payments as described in §413.64(g). We exclude HCO payments that are paid upon submission of a discharge bill from the PIP amounts. In addition, Part A costs that are not paid for under the LTCH PPS, including Medicare costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists and the costs of photocopying and mailing medical records requested by a QIO, are subject to the interim payment provisions as specified in §412.541(c).

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

VIII. RTI's Research

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

In the RY 2009 LTCH PPS proposed rule, we included a description of RTI's research, as well as two technical expert panels (TEPs) held during 2007 (73 FR 5374

through 5376). We also noted that we had posted the reports on both Phase I and Phase II of RTI's research on our Web site at http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage.

Although we did not propose any policy initiatives in the RY 2009 LTCH PPS proposed rule as a result of RTI's research, we received 10 comments on their work. We will pass these comments on to RTI and we have instructed RTI researchers to consider these concerns as they proceed with Phase III of their report.

We would also note that MedPAC's comment on our several policies that were proposed in our RY 2009 LTCH PPS proposed rule (addressed elsewhere in this preamble) included a section focusing on one significant aspect of our contract with RTI for an evaluation of the feasibility of developing patient and facility-level criteria for LTCHs. Since this contract was developed and awarded as a result of MedPAC's recommendations in its June 2004 Report to Congress (p. 120) as noted above, we believe that it is appropriate to include the following update to their initial analysis:

> The types of cases treated by LTCHs can be (and are) treated in other settings, particularly in step-down units of many acute-care hospitals. Therefore, it is not possible (nor desirable) to develop criteria defining patients who can be cared for exclusively in LTCHs. Rather, CMS should seek to define the *level of care* typically furnished in LTCHs, step-down units of many acute-care hospitals, and some specialized skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).

The Commission's entire comment is posted on the MedPAC Web site at http://www.medpac.gov/documents/03242008_LTCH_comment_DK.pdf.

In addition, we wish to take this opportunity to discuss recent developments in the related area of value-based purchasing (VBP). VBP ties payment to performance through the use of incentives based on measures of quality and cost of care. The implementation

of VBP is rapidly transforming CMS from being a passive payer of claims to an active purchaser of higher quality, more efficient health care for Medicare beneficiaries. Our VBP initiatives include hospital pay for reporting (the Reporting Hospital Quality Data for the Annual Payment Update Program), physician pay for reporting (the Physician Quality Reporting Initiative), home health pay for reporting, the Hospital VBP Plan Report to Congress, and various VBP demonstration programs across payment settings, including the Premier Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration.

The preventable hospital-acquired conditions payment provision for IPPS hospitals is another of CMS' value-based purchasing initiatives. The principle behind the hospital-acquired conditions payment provision (Medicare not paying more for hospital-acquired conditions) could be applied to all types of hospitals and Medicare payment systems for other settings of care. Section 1886(d)(4)(D) of the Act required the Secretary to select, for IPPS hospital payment purposes, hospital-acquired conditions that: (a) are high cost, high volume, or both; (b) are assigned to a higher-paying Medicare severity diagnosis-related group (MS-DRG) when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to a higher-paying MS-DRG if a selected hospital-acquired condition was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present (Medicare will continue to assign a discharge to a higher-paying MS-DRG in those instances where the selected condition was, in fact, present on admission).

The broad principle articulated in the hospital-acquired conditions payment provision could be expanded to hospitals other than IPPS hospitals, such as long-term care hospitals. Alignment of incentives across all Medicare payment systems is an important goal for CMS' VBP initiatives. Consequently, we are taking this opportunity to open the discussion of the applicability of the hospital-acquired conditions payment provision to long-term care hospitals with stakeholders in the provider community as well as with the general public as we advance in our fight against hospital-acquired conditions in all types of hospitals.

IX. Electronic Submission of Cost Reports: Revision to Effective Date of Cost Reporting Period

A. Background

In the August 22, 2003 **Federal Register** (68 FR 50717), we published the "Electronic Submission of Cost Reports" final rule requiring all hospices, organ procurement organizations (OPOs), rural health clinics (RHCs), Federally qualified health centers (FQHCs), and community mental health centers (CMHCs) to submit Medicare cost reports in a standardized electronic format. This requirement was effective for cost reporting periods ending on or after December 31, 2004.

Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years

after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule finalizes provisions set forth in May 25, 2005 interim final rule with comment period. In addition, this final rule has been published within 3 years of the interim final rule with comment period. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

B. Provisions of the Interim Final Rule with Comment Period

In the May 27, 2005 **Federal Register** (70 FR 30640 through 30643)**,** we published the "Electronic Submission of Cost Reports: Revision to Effective Date of Cost Reporting Period" interim final rule with comment period revising the existing effective date for submission of electronic cost reports for OPOs, RHCs, FQHCs, and CMHCs from cost reporting periods ending on or after December 31, 2004 to cost reporting periods ending on or after March 31, 2005.

As stated in the May 27, 2005 interim final with comment period, hospices and End-Stage Renal Disease (ESRD) facilities continue to be subject to the electronic filing requirements as referenced in the August 23, 2003 final rule as software for these provider types is available. Therefore, all hospices and ESRD facilities are still required to submit standardized electronic cost reports for cost reporting periods ending on or after December 31, 2004.

C. Analysis of and Responses to Public Comments

We received two public comments in response to the May 27, 2005 interim final rule with comment period. One comment was outside the scope of this rule because it

dealt with physical therapy and will not be addressed. The other comment agreed with our proposed change.

D. Provisions of the Final Regulations

We are finalizing the provisions of the May 27, 2005 interim final rule with comment period without change. Since the provisions of §413.24 are already codified and there are no revisions, we are not republishing the regulation text for §413.24 in this final rule.

X. Collection of Information Requirements

This document contains the regulation text associated with CMS-1393-F. The associated regulation text does not contain any information collection requirements; consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et. seq.). However, we are republishing the information collection requirements associated with CMS-1199-F. The requirements referenced and discussed below pertain to 42 CFR 413.24 and are currently approved by OMB.

Currently §413.24 requires hospitals, to submit cost reports in a standardized electronic format for cost reporting periods beginning on or after October 1, 1989. SNFs, and HHAs must submit cost reports in a standardized electronic format for cost reporting periods ending on or after December 31, 1996. Hospices, ESRD facilities, OPOS, RHCs, FQHCs and CMHCs must submit cost reports in a standardized electronic format for cost reporting periods ending on or after December 31, 2004. These reporting requirements are currently approved as described below.

This interim final rule revises the dates by which OPOs, RHCs, FQHCs, and CMHCs must submit cost reports in a standardized electronic format. Under the revised requirements OPOs, RHCs, FQHCs, and CMHCs must now submit cost reports in a standardized electronic format for cost reporting periods ending on or after March 31, 2005, rather than December 31, 2004. This change does not impose any new burden.

As noted above, while all the above reporting requirements are subject to the PRA, they are currently approved under the following OMB control numbers.

Provider Type	OMB Control Number	Expiration Date
Hospital	0938-0050	05/31/2008
Hospice Program	0938-0758	01/31/2008
Renal Dialysis Facility	0938-0236	08/31/2010
Federally Qualified Health Center	0938-0107	06/30/2008
Home Health Agency	0938-0022	08/31/2010
End Stage Renal Disease Networks	0938-0657	12/31/2009
Skilled Nursing Facility	0938-0463	06/30/2010
Organ Procurement Organization/Histocompatibility Laboratories	0938-0102	08/31/2008

We have submitted a copy of this final rule to OMB for its review of the aforementioned information collection requirements.

XI. Regulatory Impact Analysis

A. RY 2009 LTCH PPS Final Rule

1. Introduction

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

Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104-4), and Executive Order 13132.

a. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). In the impact analysis, we are using the rates, factors and policies presented in this final rule, including updated wage index values, and the best available claims and CCR data to estimate the change in payments for the 2009 LTCH PPS rate year. As stated in section IV.E. of this preamble, section 114(e)(1) of the MMSEA revises the standard Federal rate for RY 2008 by providing that "for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for 2007" (in other words, the standard Federal rate for RY 2008 is the same as the standard Federal rate for RY 2007). Also, section 114(e)(2) of the MMSEA provides that the revised standard Federal rate for RY 2008 "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008" (that is, the first 9 months of RY 2008). As noted in section IV.E. of this preamble, the standard Federal rate for RY 2007 was $38,086.04. Accordingly, the standard Federal rate for RY 2008 is $38,086.04. As discussed in section IV.E. of this preamble, consistent with our historical practice, we updated the standard Federal rate for RY 2008 by 2.7 percent in order to establish the RY

2009 standard Federal rate at $39,114.36. Furthermore, we note that section 114(c)(3) of MMSEA requires a 3-year suspension of our application of the revisions to the SSO policy at §412.529(c)(3)(i) that was finalized in the RY 2008 final rule. Both of these revisions to RY 2008 LTCH PPS payments (that is, sections 114(c)(3) and (e)(1) through (2) of MMSEA) affect the modeling of payments in this impact analysis, which we discussed in greater detail in section XVI.B.3. of this final rule. Based on the best available data for the 391 LTCHs in our database, we estimate that the update to the standard Federal rate for RY 2009 (discussed in section IV.E. of the preamble of this final rule) and the changes to the area wage adjustment (discussed in section IV.F.1. of the preamble of this final rule) for the 2009 LTCH PPS rate year, in addition to an estimated increase in SSO payments and a slight increase in HCO payments (as discussed in greater detail below) will result in an increase in estimated payments from the 2008 LTCH PPS rate year of approximately $110 million (or about 2.5 percent). Based on the 391 LTCHs in our database, we estimate RY 2008 LTCH PPS payments to be approximately $4.36 billion and RY 2009 LTCH PPS payments to be approximately $4.47 billion. Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than $100 million, this final rule is considered a major economic rule, as defined in this section. We note the approximately $110 million for the projected increase in estimated aggregate LTCH PPS payments resulting from the provisions presented in this final rule does not reflect changes in LTCH admissions or case-mix intensity in estimated LTCH PPS payments, which would also affect overall payment changes.

We note that the average combined effect of the standard Federal rate and area wage adjustment changes on estimated aggregate payments cannot be computed by simply adding up the estimated averages in columns 6 and 7 of Table V because each of those two columns are intended to show the isolated impact of the respective change (that is, the change to the standard Federal rate or the change to the area wage adjustment) on estimated payments for RY 2009 as compared to RY 2008, and the interactive effects resulting from both the change to the standard Federal rate and change to the area wage adjustment (and estimated changes to the HCO and SSO payments) are not accounted for in the modeling of estimated payments to produce the percent change in each of these columns. However, the change in estimated SSO and HCO payments, and the interactive effects of all changes are taken into account in the modeling of estimated payments for RY 2009 as compared to RY 2008 in Column 8 of Table V.

Notwithstanding this limitation in comparing the various columns in Table V, the difference between the projected increase in payments per discharge from RY 2008 to RY 2009 for all changes of 2.5 percent (column 8) and the sum of the projected increase due to the change to the standard Federal rate (1.9 percent in column 6) and the change due to the area wage adjustment (-0.1 percent in column 7) is mostly attributable to the effect of the estimated increase in payments for SSO cases and the estimated slight estimated increase in payments for HCO cases in RY 2009 as compared to RY 2008. That is, in calculating the estimated increase in payments from RY 2008 to RY 2009 for SSO and HCO cases, we increased estimated costs by the applicable market basket (approximately 3.2 percent). We note that, SSO cases comprise approximately 16 percent of estimated total LTCH PPS payments and HCO cases comprise approximately

8 percent of estimated total LTCH PPS payments. The majority of the payments for SSO cases (over 60 percent) are based on the estimated cost of the case.

While the effects of the estimated increase in SSO and HCO payments and the change to the standard Federal rate are projected to increase estimated payments per discharge from RY 2008 to RY 2009, the changes to the area wage adjustment from RY 2008 to RY 2009 are expected to result in a small decrease of 0.1 percent in estimated aggregate LTCH PPS payments from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year (see column 7 of Table V). As discussed in section IV.F.1. of this rule, we are updating the wage index values for RY 2009 based on the most recent available data. In addition, we are slightly decreasing the labor-related share from 75.788 percent to 75.662 percent under the LTCH PPS for RY 2009 based on the most recent available data on the relative importance of the labor-related share of operating and capital costs of the market basket applicable to the LTCH PPS (also discussed in section IV.F.1. of this final rule).

b. Regulatory Flexibility Act (RFA)

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

LTCHs. Therefore, we assume that all LTCHs are considered small entities for the purpose of the analysis that follows. Medicare FIs are not considered to be small entities. The Secretary certifies that this final rule would not have a significant economic impact on a substantial number of small entities.

Currently, our database of 391 LTCHs includes the data for 85 non-profit (voluntary ownership control) LTCHs and 273 proprietary LTCHs. Of the remaining 33 LTCHs, 16 LTCHs are Government-owned and operated and the ownership type of the other 17 LTCHs is unknown (as shown in Table V). The impact of the payment rate and policy changes for the 2009 LTCH PPS rate year (including the update to the standard Federal rate and the changes to the area wage adjustment) is discussed in section XVI.B.4.c. of this final rule.

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

The impact analysis of the payment rate and policy changes in Table V shows that estimated payments per discharge are expected to increase approximately 2.5 percent, on average, for all LTCHs from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year. The projected 2.5 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year is attributable to the change to the rate, the area wage adjustment (discussed in section IV.F.1. of this final rule), and estimated increases in SSO and HCO payments (as discussed in greater detail below). As Table V shows, the change in just the standard

Federal rate is projected to result in an estimated average increase of 1.9 percent in estimated payments per discharge from RY 2008 to RY 2009, on average, for all LTCHs, while just the changes to the area wage adjustment are projected to result in an estimated decrease of 0.1 percent, on average, for all LTCHs (columns 6 and 7 of Table V, respectively). A thorough discussion of the regulatory impact analysis for the changes presented in this final rule can be found below in section XI.A.3.c. of this final rule.

c. Impact on Rural Hospitals

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table V, we are projecting a 2.0 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year for rural LTCHs that would primarily result from the changes presented in this final rule (that is, the update to the standard Federal rate discussed in section IV.E. of the preamble of this final rule and the changes to the area wage adjustment as discussed in section IV.F.1. of the preamble of this final rule) based on the data of the 25 rural LTCHs in our database of 391 LTCHs for which complete data were available.

As shown in Table V, the estimated increase in estimated LTCH PPS payments from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year for rural LTCHs is primarily due to the update to the standard Federal rate (as discussed in greater detail in section IV.E. of the preamble of this final rule) and the change in the area wage adjustment (as discussed in greater detail in section V.F.1. of the preamble of this final rule) in conjunction with the estimated increased payments for SSO cases and a

slight estimated increase in payments to HCO cases (as discussed below in section XI.A. 2.c. of this final rule). We believe that the changes to the area wage adjustment presented in this final rule (that is, the use of updated wage data and the change in the labor-related share) will result in accurate and appropriate LTCH PPS payments in RY 2009 since they are based on the most recent available data. Such updated data appropriately reflect national differences in area wage levels and identifies the portion of the standard Federal rate that should be adjusted to account for such differences in area wages, thereby resulting in accurate and appropriate LTCH PPS payments.

d. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $130 million. This final rule would not mandate any requirements for State, local, or tribal governments, nor would it result in expenditures by the private sector of $130 million or more in any 1 year.

e. Federalism

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

We have examined this final rule under the criteria set forth in Executive Order 13132 and have determined that this final rule will not have any significant impact on the

rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 16 State and local LTCHs (that is, Government ownership type) in our database of 391 LTCHs for which data were available.

f. Alternatives Considered

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

2. Anticipated Effects of Payment Rate Changes

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

a. Budgetary Impact

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

b. Impact on Providers

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

To understand the impact of the changes to the LTCH PPS payments discussed in section IV. of this final rule on different categories of LTCHs for the 2009 LTCH PPS rate year, it is necessary to estimate payments per discharge for the 2008 LTCH PPS rate year using the rates, factors and policies established in the RY 2008 LTCH PPS final rule (72 FR 26870 through 27029), the RY 2008 LTCH PPS correction notice (72 FR 36613 through 36616) and the applicable sections of MMSEA (as described in greater detail below in section XI.A.2.c. of this final rule). It is also necessary to estimate the payments per discharge that will be made under the LTCH PPS rates, factors and policies for the 2009 LTCH PPS rate year (as discussed in the preamble of this final rule). These estimates of RY 2008 and RY 2009 LTCH PPS payments are based on the best available LTCH claims data and other factors such as the application of inflation factors to estimate costs for SSO and HCO cases in each year. We also evaluated the change in estimated 2008 LTCH PPS rate year payments to estimated 2009 LTCH PPS rate year payments (on a per discharge basis) for each category of LTCHs.

Hospital groups were based on characteristics provided in the OSCAR data, FY 2004 through FY 2006 cost report data in HCRIS, and PSF data. Hospitals with

incomplete characteristics were grouped into the "unknown" category. Hospital groups include the following:

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

To estimate the impacts of the payment rates and policy changes among the various categories of existing providers, we used LTCH cases from the FY 2007 MedPAR file to estimate payments for RY 2008 and to estimate payments for RY 2009 for 391 LTCHs. While currently there are just under 400 LTCHs, the most recent growth is predominantly in for-profit LTCHs that provide respiratory and ventilator-dependent patient care. We believe that the discharges from the FY 2007 MedPAR data for the 391 LTCHs in our database, which includes 273 proprietary LTCHs, provide sufficient representation in the MS-LTC-DRGs containing discharges for patients who received LTCH care for the most commonly treated LTCH patients' diagnoses.

c. Calculation of Prospective Payments

For purposes of this impact analysis, to estimate per discharge payments under the LTCH PPS, we simulated payments on a case-by-case basis using LTCH claims from the FY 2007 MedPAR files. In the impact analysis for the proposed rule, for modeling estimated LTCH PPS payments for both RY 2008 and RY 2009, we had applied the RY 2008 standard Federal rate (that is, $38,086.04) provided for by section 114(e) of MMSEA, and the SSO policy provided for by section 114(c)(3) of the MMSEA (that is,

excluding the revisions to the SSO policy at §412.529(c)(3)(i) of the regulations). Although we were aware at the time that the effective date for the change in the SSO policy during RY 2008 in the MMSEA is December 29, 2007, and that discharges occurring on or after July 1, 2007 and before April 1, 2008 are not paid under the RY 2008 standard Federal rate in 1886(m)(2) of the Act, nonetheless, for purposes of that impact analysis in the proposed rule, we applied both the MMSEA revised SSO policy and MMSEA revised standard Federal rate for all of RY 2008 in the estimation of RY 2008 LTCH PPS payments. Similarly, in modeling LTCH PPS payments in the proposed rule to project the average change in estimated payments per discharge from RY 2008 to RY 2009 due to the change in the standard Federal rate, rather than using the RY 2008 standard Federal rate finalized in the RY 2008 final rule, we compared the MMSEA revised RY 2008 standard Federal rate (that is, $38,086.04), to the proposed RY 2009 standard Federal rate of $39,076.28 (that is, $38,086.04 updated by the proposed 2.6 percent update factor, as discussed in the RY 2009 proposed rule (73 FR 5361 through 5362)) in order to estimate the effect of proposing to update the standard Federal rate by 2.6 percent. As we discussed in the RY 2009 proposed rule (73 FR 5379), we took this approach for the impact analysis in the proposed rule since for the last 3 months of the 2008 LTCH PPS rate year (that is, April 2008 through June 2008), which is the 3-month period immediately preceding the start of the 2009 LTCH PPS rate year, LTCH discharges are paid under the RY 2008 standard Federal rate and SSO policy established by section 114 of the MMSEA. However, we received a comment on the impact analysis of the proposed rule.

Comment: A commenter disagreed with our methodology for projecting RY 2008 estimated payments as if the MMSEA provisions on the SSO policy and RY 2008 standard Federal rate (that is, sections 114(c)(3) and 114(c)(1) of the MMSEA) had been in effect for all of RY 2008. The commenter believed that we were overstating the projected increase in estimated payments for RY 2009 in the proposed rule because we did not fully account for the MMSEA provisions that affect the projection of RY 2008 estimated payments. The commenter suggested that we fully account for the MMSEA changes to the standard Federal rate for 2008, the SSO payment policy, and the "25 percent rule" at 42 CFR 412.534 and 412.536, in our impact analysis.

Response: Regarding the "25 percent rule" at 42 CFR 412.534 and 412.536, we note that historically, we have not included this policy in our impact analysis. We are not aware of any instances where the FI has made any adjustments under this policy. Consequently, our impact analysis does not include any effect on estimated payments for RY 2008 or RY 2009 due to the "25 percent rule" at 42 CFR 412.534 and 412.536. With respect to commenters' suggestion that we model payments for the MMSEA changes according to the timeframes set forth in the MMSEA, instead of our approach in which we projected RY 2008 payments as if discharges during all of the RY 2008 were paid under the MMSEA revised standard Federal rate and MMSEA revised SSO policy for all of RY 2008 we agree that our approach may have resulted in slightly overstating the estimate of the change in payments from RY 2008 to RY 2009 in the proposed rule. Therefore, to address this concern, we modified the impact analysis for this final rule. Specifically, for purposes of the impact analysis in this final rule, rather than applying the MMSEA revised SSO policy and MMSEA revised RY 2008 standard Federal rate to

discharges for all of RY 2008 in the estimation of RY 2008 LTCH PPS payments, we accounted for the effect on LTCH payments as a result of the MMSEA changes to these two policies during RY 2008. That is, for the first 9 months of RY 2008 (July 1, 2007 through March 31, 2008), estimated LTCH payments for LTCH discharges were determined based on the "higher" rate of $38,356.45, while for the last 3 months of RY 2008 (April 1, 2008 through June 30, 2008), estimated LTCH payments for LTCH discharges were determined based on the "lower" MMSEA revised RY 2008 standard Federal rate of $38,086.04. Additionally, we modeled estimated RY 2008 LTCH PPS payments by incorporating the change to the SSO policy, which excludes the revisions to the SSO policy at §412.529(c)(3)(i), that occurred midyear in RY 2008 in accordance with the MMSEA. (Additional information on section 114 of the MMSEA can be found at section I.A. of this final rule.)

Furthermore, in modeling estimated LTCH PPS payments for both RY 2008 and RY 2009 in this impact analysis, we applied the RY 2008 and RY 2009 adjustments for area wage differences (as described in section IV.F.1. of the preamble of this final rule), and the COLA for Alaska and Hawaii (as described in section IV.F.2. of the preamble of this final rule). Specifically, we adjusted for area wage differences for estimated 2008 LTCH PPS rate year payments using the current LTCH PPS labor-related share of 75.788 percent (72 FR 26892), the wage index values established in the Tables 1 and 2 of the Addendum of the RY 2008 final rule (72 FR 26996 through 27019) and the COLA factors established in Table III of the preamble of the RY 2008 final rule (72 FR 26894). Similarly, we adjusted for area wage differences for estimated 2009 LTCH PPS rate year payments using the LTCH PPS labor-related share of 75.662 percent (see section

IV.D.1.c. of this final rule), the wage index values presented in the Tables 1 and 2 of the Addendum of this final rule and the COLA factors established in Table III of the preamble of this final rule.

As discussed above, we also accounted for the payment policy for SSOs**.** We also estimated additional payments that would be made for HCOs (as described in section IV.F.3. of this final rule). In modeling payments for SSO and HCO cases in RY 2008, we applied an inflation factor of 1.025 percent (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2007 MedPAR files and the best available CCRs from the January 2008 update of the PSF. In modeling payments for SSO and HCO cases in RY 2009, we applied an inflation factor of 1.058 (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2007 MedPAR files and the best available CCRs from the January 2008 update of the PSF. As noted in section IV.F.4. of this final rule, we are not making adjustments for rural location, geographic reclassification, indirect medical education costs, or a DSH payment for the treatment of low-income patients because our most recent data analysis that reflects LTCH behavior subsequent to the implementation of the LTCH PPS indicates that payment adjustments for geographic reclassification, rural location, DSH, or indirect medical education costs would not improve the accuracy of payments made under the LTCH PPS to LTCHs. (See Section IV.F.4. of this final rule.).

These impacts reflect the estimated "losses" or "gains" among the various classifications of LTCHs from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year based on the payment rates and policy changes presented in this final rule. Table V

illustrates the estimated aggregate impact of the LTCH PPS among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of LTCH cases.
- The fourth column shows the estimated payment per discharge for the 2008 LTCH PPS rate year (as described above).
- The fifth column shows the estimated payment per discharge for the 2009 LTCH PPS rate year (as described above).
- The sixth column shows the percentage change in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for changes to the standard Federal rate (as discussed in section IV.E. of the preamble of this final rule).
- The seventh column shows the percentage change in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for changes to the area wage adjustment at §412.525(c) (as discussed in section IV.F.1. of the preamble of this final rule).
- The eighth column shows the percentage change in estimated payments per discharge from the 2008 LTCH PPS rate year (column 4) to the 2009 LTCH PPS rate year (column 5) for all changes.

TABLE V: Impact of Payment Rate and Payment Rate Policy Changes to LTCH PPS Payments for RY 2009 (Estimated 2008 LTCH PPS Rate Year Payments Compared to Estimated 2009 LTCH PPS Rate Year Payments*)

LTCH Classification	Number of LTCHs	Number of LTCH PPS Cases	Average Estimated RY 2008 LTCH PPS Rate Year Payment Per Case [1]	Average Estimated RY 2009 LTCH PPS Rate Year Payment Per Case [2]	Percent Change in Estimated Payments Per Discharge from RY 2008 to RY 2009 for Finalized Changes to the Federal Rate [3]	Percent Change in Estimated Payments Per Discharge from RY 2008 to RY 2009 for Finalized Changes to the Area Wage Adjustment [4]	Percent Change in Payments Per Discharge from RY 2008 to RY 2009 for All Changes [5]
ALL PROVIDERS	391	129,255	$33,698	$34,545	1.9	-0.1	2.5
BY LOCATION:							
RURAL	25	6,150	$27,457	$28,019	2.0	-0.4	2.0
URBAN	366	123,105	$34,010	$34,871	1.9	-0.1	2.5
LARGE	188	74,266	$35,399	$36,322	1.8	0.0	2.6
OTHER	178	48,839	$31,898	$32,665	1.9	-0.2	2.4
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	17	6,927	$29,776	$30,691	1.9	0.5	3.1
OCT. 1983 - SEPT. 1993	46	18,659	$35,173	$36,050	1.8	-0.1	2.5
OCT. 1993 - SEPT. 2002	201	69,664	$33,286	$34,080	1.9	-0.2	2.4
AFTER OCTOBER 2002	120	32,289	$34,184	$35,090	1.9	0.0	2.7
UNKNOWN PARTICIPATION DATE	7	1,716	$41,097	$42,368	1.8	0.5	3.1
BY OWNERSHIP TYPE:							
VOLUNTARY	85	22,712	$34,269	$35,184	1.8	0.0	2.7
PROPRIETARY	273	101,601	$33,441	$34,266	1.9	-0.2	2.5
GOVERNMENT	16	2,370	$36,129	$37,151	1.8	0.2	2.8
UNKNOWN OWNERSHIP TYPE	17	2,572	$36,564	$37,539	1.9	0.0	2.7
BY REGION:							

LTCH Classification	Number of LTCHs	Number of LTCH PPS Cases	Average Estimated RY 2008 LTCH PPS Rate Year Payment Per Case [1]	Average Estimated RY 2009 LTCH PPS Rate Year Payment Per Case [2]	Percent Change in Estimated Payments Per Discharge from RY 2008 to RY 2009 for Finalized Changes to the Federal Rate [3]	Percent Change in Estimated Payments Per Discharge from RY 2008 to RY 2009 for Finalized Changes to the Area Wage Adjustment [4]	Percent Change in Payments Per Discharge from RY 2008 to RY 2009 for All Changes [5]
NEW ENGLAND	16	8,266	$30,010	$30,969	1.9	0.7	3.2
MIDDLE ATLANTIC	29	8,135	$34,623	$35,341	1.8	-0.6	2.1
SOUTH ATLANTIC	49	13,364	$38,348	$39,354	1.8	-0.1	2.6
EAST NORTH CENTRAL	67	19,180	$37,205	$38,117	1.9	-0.2	2.5
EAST SOUTH CENTRAL	31	8,343	$33,095	$33,763	1.9	-0.6	2.0
WEST NORTH CENTRAL	19	5,199	$35,471	$36,415	1.9	0.0	2.7
WEST SOUTH CENTRAL	134	50,770	$29,655	$30,343	1.9	-0.3	2.3
MOUNTAIN	25	5,569	$35,779	$36,774	1.8	0.0	2.8
PACIFIC	21	10,429	$41,664	$42,987	1.8	0.6	3.2
BY BED SIZE:							
BEDS: 0-24	34	4,633	$30,444	$31,044	2.0	-0.6	2.0
BEDS: 25-49	195	44,616	$33,618	$34,440	1.9	-0.2	2.4
BEDS: 50-74	78	26,845	$33,393	$34,248	1.9	-0.1	2.6
BEDS: 75-124	47	22,806	$36,034	$37,013	1.8	0.1	2.7
BEDS: 125-199	21	16,536	$32,717	$33,514	1.9	-0.2	2.4
BEDS: 200 +	16	13,819	$32,961	$33,798	1.9	-0.1	2.5

[1] Estimated 2008 LTCH PPS rate year payments based on the rates, factors and policies established in the RY 2008 LTCH PPS final rule (72 FR 26870 through 27029), the RY 2008 LTCH PPS correction notice (72 FR 36613 through 36616) and the applicable sections of the MMSEA. As described in section XVI.B.3. of this final rule, for the purpose of this impact analysis, we modeled estimated RY 2008 payments based on the MMSEA provisions regarding the application of the revised standard Federal rate for RY 2008 and the revised SSO policy. Specifically, in estimating RY 2008 LTCH PPS payments, we applied the MMSEA revised RY 2008 standard Federal rate of $38,086.04 to 3 months of RY 2008 (that is, April 1, 2008 through June 30, 2008) and we applied the RY 2008 rate from the RY 2008 LTCH PPS final rule of $38,356.45 to 9 months of RY 2008 (that is, July 1, 2007 though March 31, 2008). Additionally, in estimating RY 2008 LTCH PPS payments, we accounted for the midyear change to the SSO policy provided for by section 114(c)(3) of the MMSA (that is, excluding the revisions to the SSO policy at §412.529(c)(3)(i)) for discharges occurring on or after December 29, 2007.

[2] Estimated 2009 LTCH PPS rate year payments based on the payment rates and policy changes presented in the preamble of this final rule.

[3] Percent change in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for the changes to the Federal rate, as discussed in section IV.E. of the preamble of this final rule. (Note, because about 34 percent of all LTCH cases are projected to receive a payment adjustment under the SSO policy that is based either on the estimated cost of the case or the "blend option" (which is based in part on the "IPPS comparable amount") rather than the Federal rate in RY 2009, the percent change in estimated payments per discharge due to the changes to the Federal rate for most of the categories of LTCHs, 1.9 percent, is somewhat less than the update to the Federal rate of 2.7 percent. In addition, since payments in RY 2008 were modeled based on the two rates applied during RY 2008 as described above, the estimated increase in payments to those cases that were

paid based on the "higher" RY 2008 rate from the RY 2008 LTCH PPS final rule (approximately 75 percent of cases) will be less than the 2.7 percent update that was applied to the "lower" revised RY 2008 standard Federal rate in determining the RY 2009 Federal rate.)

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

[5] Percent change in estimated payments per discharge from the 2008 LTCH PPS rate year (as described in section XI.A.2.c. of this final rule) to the 2009 LTCH PPS rate year including all of the changes presented in the preamble of this final rule. Note, this column, which shows the percent change in estimated payments per discharge for all changes, may not equal the sum of the percent changes in estimated payments per discharge for changes to the standard Federal rate (column 6) and the changes to the area wage adjustment (column 7) due to the effect of estimated changes in both payments to SSO cases that are paid based on estimated costs and aggregate HCO payments (as discussed this final rule), as well as other interactive effects that cannot be isolated.

d. Results

Based on the most recent available data (as described previously for 391 LTCHs), we have prepared the following summary of the impact (as shown in Table V) of the LTCH PPS payment rate and policy changes presented in this final rule. The impact analysis in Table V shows that estimated payments per discharge are expected to increase approximately 2.5 percent, on average, for all LTCHs from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year as a result of the payment rate and policy changes presented in this final rule. We note that although we are proposing a 2.7 percent increase to the standard Federal rate for RY 2009, based on the latest market basket estimate (3.6 percent) for the 15-month 2009 rate year and offset by the coding and documentation adjustment (0.9 percent), for most categories of LTCHs, the impact analysis shown in Table V only shows a 1.9 percent increase (column 6) in estimated payments per discharge from RY 2008 to RY 2009 as a result of the change to the standard Federal rate. The projected impact of 1.9 percent for the change in the standard Federal rate shown in column 6 is less than the 2.7 percent update to the standard Federal rate discussed in section IV.C. of the preamble due to several factors. First, as we discussed above, we modified the impact analysis for this final rule in response to a comment we received on the impact analysis performed for the proposed rule. Specifically, in our modeling of estimated payments for RY 2008, we accounted for the mid-year change in the SSO payment policy that occurred during RY 2008 and incorporated both the "lower" MMSEA revised RY 2008 standard Federal rate, under which discharges are paid for 3 months, and the "higher" rate from the RY 2008 LTCH PPS final rule, under which discharges are paid for 9 months, in accordance with the

MMSEA as discussed above and in more detail in section I.E. of this preamble. Since payments in RY 2008 were modeled based on the two rates under which discharges are paid during RY 2008 as described above, the estimated increase in payments to those cases that were paid based on the "higher" RY 2008 rate from the RY 2008 LTCH PPS final rule (approximately 75 percent of cases) will be less than the 2.7 percent update that was applied to the "lower" MMSEA revised RY 2008 standard Federal rate in determining the RY 2009 Federal rate. Furthermore, approximately 30 percent of LTCH cases are SSO cases, which are paid based on the estimated cost of the case or the blend option one component of which is the IPPS comparable amount rather than on the updated Federal rate. The inclusion of the estimated payments for these SSO cases in the estimate of the average payment per discharge for all LTCH cases results in an estimated increase that is less than the 2.7 percent update to the standard Federal rate. Therefore, because over 30 percent of all LTCH PPS cases are projected to receive a payment that is not based fully on the standard Federal rate, the percent change in estimated payments per discharge due to the change to the standard Federal rate for most categories of LTCHs shown in Table V is projected to be 1.9 percent, which is somewhat less than the 2.5 percent update to the standard Federal rate. In addition to the 1.9 percent increase to the standard Federal rate for RY 2009, the projected percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year of 2.5 percent shown in Table V (see column 8) reflects the effect of estimated SSO payments and a slight increase in estimated HCO payments as we discussed previously. That is, in calculating the estimated increase in payments for HCO and SSO from RY 2008 to RY 2009, we increased costs by applying the applicable market basket

(approximately 3.2 percent). As noted above, SSOs comprise approximately 16 percent of total LTCH PPS payments and HCOs comprise approximately 8 percent of estimated total LTCH PPS payments. Furthermore, as discussed previously in this regulatory impact analysis, the average increase in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year, on average, for all LTCHs is approximately 2.5 (as shown in Table V) and was determined by comparing estimated RY 2009 LTCH PPS payments (using the rates and policies discussed in the preamble of this rule) to estimated RY 2008 LTCH PPS payments (as described above in section XI.A.2.c. of this regulatory impact analysis).

(1) Location

Based on the most recent available data, the majority of LTCHs are in urban areas. Approximately 6 percent of the LTCHs are identified as being located in a rural area, and approximately 5 percent of all LTCH cases are treated in these rural hospitals. The impact analysis presented in Table V shows that the average percent increase in estimated payments per discharge for the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year for all hospitals is 2.5 percent for all changes. For rural LTCHs, the percent change for all changes is estimated to be 2.0 percent, while for urban LTCHs, we estimate this increase to be 2.5 percent. Large urban LTCHs are projected to experience a 2.6 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, while other urban LTCHs are projected to experience a 2.4 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, as shown in Table V. Rural LTCHs are projected to experience a somewhat lower than

average increase in estimated payments per discharge for all changes primarily due to the changes to the area wage adjustment (0.4 percent, see column 7 of table V). That is, 72 percent of the LTCHs in these areas are expected to experience a decrease in their wage index value from RY 2008 to RY 2009.

(2) Participation Date

LTCHs are grouped by participation date into four categories: (1) before October 1983; (2) between October 1983 and September 1993; (3) between October 1993 and September 2002; and (4) after October 2002. Based on the most recent available data, the majority (approximately 51 percent) of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience about the average increase (2.4 percent) in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, as shown in Table V.

LTCHs that began participating in Medicare between October 1983 and September 1993, are projected to experience the average percent increase (2.5 percent) in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, as shown in Table V. Approximately 12 percent of LTCHs began participating in Medicare between October 1983 and September 1993 while approximately 31 percent of LTCHs began participating in Medicare after October 2002 (that is, the beginning of the LTCH PPS, which was implemented for cost reporting periods beginning on or after October 1, 2002). LTCHs that began participating in Medicare after October 2002 are projected to experience a slightly higher than average percent increase (2.7 percent) in estimated payments per discharge from the 2008

LTCH PPS rate year compared to the 2009 LTCH PPS rate year, as shown in Table V. Similarly, LTCHs that began participating before October 1983 are projected to experience higher than the average increase (3.1 percent) in estimated payments per discharge for the 2009 LTCH PPS rate year as compared to the 2008 LTCH PPS rate year (see Table V).

(3) Ownership Control

Other than LTCHs whose ownership control type is unknown, LTCHs are grouped into three categories based on ownership control type: voluntary; proprietary; and government. Based on the most recent available data, approximately 4 percent of LTCHs are identified as government-owned and operated (see Table V). We expect that for these government-owned and operated LTCHs, estimated 2009 LTCH PPS rate year payments per discharge will increase 2.8 percent in comparison to the 2008 LTCH PPS rate year, as shown in Table V. We are projecting that government-run LTCHs will experience a somewhat higher than average increase in estimated payments in RY 2009 as compared to RY 2008 primarily due to the effect of the changes to the area wage adjustment. Specifically, the majority (69 percent) of hospitals in this category are projected to experience an increase in their wage index value from RY 2008 to RY 2009. In addition, because the majority (approximately 75 percent) of hospitals in this category have a wage index of less than 1.0, the decrease to the labor-related share (from 75.788 percent to 75.662 percent) also contributes to the larger than average increase in estimated payments for RY 2009 as compared to RY 2008, shown in Table V.

We project that estimated 2009 LTCH PPS rate year payments per discharge for voluntary LTCHs, which account for approximately 22 percent of LTCHs, will increase

slightly higher than the average (2.7 percent) in comparison to estimated 2008 LTCH PPS rate year payments (see Table V). The majority (approximately 70 percent) of LTCHs are identified as proprietary. We project that RY 2009 estimated payments per discharge for these proprietary LTCHs will increase by the average (2.5 percent) in comparison to the 2008 LTCH PPS rate year (see Table V).

(4) Census Region

Estimated payments per discharge for the 2009 LTCH PPS rate year are projected to increase for LTCHs located in all regions in comparison to the 2008 LTCH PPS rate year. The percent increase in estimated payments per discharge for the 2009 LTCH PPS rate year as compared to the 2008 LTCH PPS rate year for all regions is largely attributable to the increase in the standard Federal rate, while the variations in the estimated percent increases in payments ranging from 2.0 percent to 3.2 percent, is primarily due to the differences in estimated payment changes due to changes to the area wage adjustment.

Of the 9 census regions, we project that the increase in 2009 LTCH PPS rate year estimated payments per discharge in comparison to the 2008 LTCH PPS rate year will have the largest impact on LTCHs in the New England and Pacific regions (3.2 percent for both; see Table V). LTCHs located in both the New England and Pacific regions are expected to experience a larger than average increase in estimated payments due to the changes in the area wage adjustment (0.7 percent for the New England region, and 0.6 percent for the Pacific region, as shown in Table V). This is because approximately 87 percent of LTCHs located in the New England region and all of LTCHs in the Pacific

region are projected to experience an increase in their wage index values for RY 2009 as compared to RY 2008.

For LTCHs located in the Middle Atlantic and East South Central regions, we estimate that the somewhat lower than average projected increase (2.1 percent and 2.0 percent, respectively) in estimated payments per discharge for the 2009 LTCH PPS rate year compared to the 2008 LTCH PPS rate year is largely a result of the changes to the area wage adjustment. Specifically, the vast majority of LTCHs in the Middle Atlantic region (approximately 86 percent) and East South Central region (approximately 71 percent) would experience a decrease in their wage index value from RY 2008 to RY 2009 which contributes to the lower than average estimated increase in payments from RY 2008 to RY 2009.

We project that in comparison to the 2008 LTCH PPS rate year, the 2009 LTCH PPS rate year estimated payments per discharge for LTCHs in the West North Central, South Atlantic, East North Central, and West South Central regions will increase near the average (2.7 percent, 2.6 percent, 2.5 percent, and 2.3 percent, respectively). For LTCHs located in the Mountain region, we estimate that the slightly higher than average projected increase (2.8 percent) in estimated payments per discharge for the 2009 LTCH PPS rate year compared to the 2008 LTCH PPS rate year is a result of the changes to the area wage adjustment. That is, we estimate that a slight majority, (52 percent) of hospitals in the Mountain region will experience an increase in their wage index values from RY 2008 to RY 2009.

(5) 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 greater than 200 beds.

We are projecting an increase in estimated 2009 LTCH PPS rate year payments per discharge in comparison to the 2008 LTCH PPS rate year for all bed size categories. Most LTCHs are in bed size categories where estimated 2009 LTCH PPS rate year payments per discharge are projected to increase at or near the average increase of 2.5 percent for all LTCHS, in comparison to estimated 2008 LTCH PPS rate year payments per discharge (that is, all LTCH bed size categories except the category of LTCHs with 0-24 beds). Specifically, estimated payments per discharge for the 2009 LTCH PPS rate year are projected to increase for LTCHs with 25-49 and 125-199 beds at 2.4 percent, for LTCHs with more than 200 beds at 2.5 percent, for LTCHs with 50-74 beds at 2.6 percent, and for LTCHs with more 75-124 beds, at 2.7 percent.

Estimated payments per discharge for the 2009 LTCH PPS rate year for LTCHs with 0-24 beds are projected to have a somewhat lower than average increase (2.0 percent) in comparison to all hospitals. This lower than average increase in estimated payments per discharge for LTCHs with 0-24 beds is largely due to the changes to the area wage adjustment. Specifically, LTCHs in this category are expected to experience a larger than average decrease in their payments from RY 2008 to RY 2009 due to the changes to the area wage adjustment primarily because approximately 74 percent of the hospitals in this category are projected to experience a decrease in their wage index value from RY 2008 to RY 2009.

e. Effect on the Medicare Program

Based on actuarial projections, an estimate of Medicare spending (total estimated Medicare program payments) for LTCH services over the next 5 years based on current LTCH PPS policy (as established in previous LTCH PPS final rules) is shown in Table IV in section IV.D. of the preamble of this rule. As noted previously, we project that the provisions of this rule will result in an increase in estimated aggregate LTCH PPS payments in RY 2009 of approximately 110 million (or about 2.5 percent) for the 391 LTCHs in our database.

Consistent with the statutory requirement for budget neutrality, as we discussed in the August 30, 2002 final rule that implemented the LTCH PPS, in developing the LTCH PPS, we intended estimated aggregate payments under the LTCH PPS in FY 2003 be projected to equal the estimated aggregate payments that would have been made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the BN calculations for determining the FY 2003 standard Federal rate used the best available data and necessarily reflects assumptions. As discussed in section IV.D. of this rule, section 114(c)(4) of the MMSEA provides that the "Secretary shall not, for the 3-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in §412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision." That provision delays the effective date of any one-time budget neutrality adjustment until no earlier than December 29, 2010. However, prior to the enactment of the MMSEA of 2007, we had developed a methodology for evaluating the appropriateness of proposing a one-time budget neutrality adjustment under existing §412.523(d)(3). In order to inform the public of our thinking, and to stimulate comments

for our consideration during the three-year delay in implementing any adjustment under the recent legislation, we have presented our analysis and its results in section IV.D. of the preamble of the RY 2009 LTCH PPS proposed rule (73 FR 5376 through 5383).

f. Effect on Medicare Beneficiaries

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

3. Accounting Statement

As discussed in section XVI.A.1. of this final rule, the impact analysis of this final rule projects an increase in estimated aggregate payments of approximately $110 million (or about 2.5 percent) for the 391 LTCHs in our database. Therefore, as required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table V, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table VI provides our best estimate of the increase in Medicare payments under the LTCH PPS as a result of the provisions presented in this final rule based on the data for the 391 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE VI: Accounting Statement: Classification of Estimated Expenditures, from the 2008 LTCH PPS Rate Year to the 2009 LTCH PPS Rate Year [In Millions]

Category	TRANSFERS
Annualized Monetized Transfers	Positive transfer - Estimated increase in expenditures: $110 million

From Whom To Whom?	Federal Government To LTCH Medicare Providers

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

B. Electronic Submission of Cost Reports: Revision to Effective Date of Cost Reporting Period

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804 (2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6.5 million to $31.5 million in any 1 year. Individuals and States are not included in

the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. The threshold level is currently approximately $130 million. This rule will have no consequential effect on the governments mentioned or on the private sector.

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. Since this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

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

List of Subjects

42 CFR Part 412

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

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

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

Subpart O—Prospective Payment System for Long Term Care Hospitals

2. Section 412.503 is amended by--

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

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

The revision and additions read as follows:

§412.503 Definitions

* * * * *

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

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

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

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

* * * * *

Rural area means--(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in §412.62(f)(1)(iii);

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

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

Urban area means--(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in §412.62(f)(1)(ii);

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

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

3. Section 412.523 is amended by--

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

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

C. Revising paragraph (d)(3).

The addition and revisions read as follows:

§412.523 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(3) * * *

(v) For long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009. The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 2.7 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

(d) * * *

(3) The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates no earlier than December 29, 2010, and by no later than October 1, 2012, so that the effect of any significant difference between the data used in the original computations of budget neutrality for FY 2003 and more recent data to determine budget neutrality for FY 2003 is not perpetuated in the prospective payment rates for future years.

* * * * *

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

§412.525 Adjustments to the Federal prospective payment.

* * * * *

(c) Adjustments for area levels. The labor portion of a long-term care hospital's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS), which reflects

the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined in accordance with the definitions set forth in §412.503) of the hospital compared to the national average level of hospital wages and wage-related costs. The appropriate wage index (established by CMS) is updated annually.

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

§412.529 Special payment provision for short-stay outliers.

* * * * *

(d) * * *

(4) * * *

(ii) * * *

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

* * * * *

(iii) * * *

(B) Is adjusted for the applicable geographic adjustment factors, including local cost variation based on the geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment system wage index value for

nonreclassified hospitals and, applicable large urban location cost of living adjustment factors for LTCHs in Alaska and Hawaii, if applicable.

* * * * *

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

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

* * * * *

(d) * * *

(1) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in §412.503 and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who were admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that were otherwise payable under §412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's patients are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

* * * * *

(f) * * *

(2) * * *

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

* * *

(3) * * *

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

* * * * *

7. Section 412.535 is amended by--

A. Revising the introductory text.

B. Revising paragraph (a).

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

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

The revisions and additions read as follows:

§412.535 Publication of the Federal prospective payment rates.

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

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

(b) For the period beginning on July 1, 2008 and ending on September 30, 2009, information of the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of the long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

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

* * * * *

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

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

* * * * *

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

* * * * *

(e) * * *

(2) * * *

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

* * * * *

(3) * * *

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

* * * * *

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

Dated: _____

_____

Kerry Weems,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: _____

_____

Michael O. Leavitt,

Secretary.

BILLING CODE 4120-01-P

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

ADDENDUM:

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

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

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

Table 3: FY 2008 MS-LTC-DRG Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier Threshold (effective for discharges occurring on or after July 1, 2008 through September 30, 2009)). (Note: This table is the same information provided in Table 11 of the FY 2008 IPPS final rule (72 FR 48143 through 48157), which has been reprinted here for convenience.)

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

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
10180	Abilene, TX	
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	0.7957
10380	Aguadilla-Isabela-San Sebastián, PR	
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	0.3448
10420	Akron, OH	
	Portage County, OH	
	Summit County, OH	0.8794
10500	Albany, GA	
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	0.8514
10580	Albany-Schenectady-Troy, NY	
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	0.8588
10740	Albuquerque, NM	
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	0.9554
10780	Alexandria, LA	
	Grant Parish, LA	
	Rapides Parish, LA	0.7979

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ	
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	0.9865
11020	Altoona, PA	
	Blair County, PA	0.8618
11100	Amarillo, TX	
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	0.9116
11180	Ames, IA	
	Story County, IA	1.0046
11260	Anchorage, AK	
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	1.1913
11300	Anderson, IN	
	Madison County, IN	0.8827
11340	Anderson, SC	
	Anderson County, SC	0.9086
11460	Ann Arbor, MI	
	Washtenaw County, MI	1.0539
11500	Anniston-Oxford, AL	
	Calhoun County, AL	0.7926
11540	Appleton, WI	
	Calumet County, WI	
	Outagamie County, WI	0.9598
11700	Asheville, NC	
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	0.9185
12020	Athens-Clarke County, GA	
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	1.0517

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA	
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	0.9828
12100	Atlantic City, NJ	
	Atlantic County, NJ	1.2198
12220	Auburn-Opelika, AL	
	Lee County, AL	0.8090
12260	Augusta-Richmond County, GA-SC	
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	0.9645

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
12420	Austin-Round Rock, TX	
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	0.9544
12540	Bakersfield, CA	
	Kern County, CA	1.1051
12580	Baltimore-Towson, MD	
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	1.0134
12620	Bangor, ME	
	Penobscot County, ME	0.9978
12700	Barnstable Town, MA	
	Barnstable County, MA	1.2603
12940	Baton Rouge, LA	
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	0.8034
12980	Battle Creek, MI	
	Calhoun County, MI	1.0179
13020	Bay City, MI	
	Bay County, MI	0.8897
13140	Beaumont-Port Arthur, TX	
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	0.8531
13380	Bellingham, WA	
	Whatcom County, WA	1.1474
13460	Bend, OR	
	Deschutes County, OR	1.0942

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
13644	Bethesda-Gaithersburg-Frederick, MD	
	Frederick County, MD	
	Montgomery County, MD	1.0511
13740	Billings, MT	
	Carbon County, MT	
	Yellowstone County, MT	0.8666
13780	Binghamton, NY	
	Broome County, NY	
	Tioga County, NY	0.8949
13820	Birmingham-Hoover, AL	
	Bibb County, AL	
	Blount County, AL	
	Chilton County, AL	
	Jefferson County, AL	
	St. Clair County, AL	
	Shelby County, AL	
	Walker County, AL	0.8898
13900	Bismarck, ND	
	Burleigh County, ND	
	Morton County, ND	0.7225
13980	Blacksburg-Christiansburg-Radford, VA	
	Giles County, VA	
	Montgomery County, VA	
	Pulaski County, VA	
	Radford City, VA	0.8192
14020	Bloomington, IN	
	Greene County, IN	
	Monroe County, IN	
	Owen County, IN	0.8915
14060	Bloomington-Normal, IL	
	McLean County, IL	0.9325
14260	Boise City-Nampa, ID	
	Ada County, ID	
	Boise County, ID	
	Canyon County, ID	
	Gem County, ID	
	Owyhee County, ID	0.9465
14484	Boston-Quincy, MA	
	Norfolk County, MA	
	Plymouth County, MA	
	Suffolk County, MA	1.1792
14500	Boulder, CO	
	Boulder County, CO	1.0426

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
14540	Bowling Green, KY	
	Edmonson County, KY	
	Warren County, KY	0.8159
14740	Bremerton-Silverdale, WA	
	Kitsap County, WA	1.0904
14860	Bridgeport-Stamford-Norwalk, CT	
	Fairfield County, CT	1.2735
15180	Brownsville-Harlingen, TX	
	Cameron County, TX	0.8914
15260	Brunswick, GA	
	Brantley County, GA	
	Glynn County, GA	
	McIntosh County, GA	0.9475
15380	Buffalo-Niagara Falls, NY	
	Erie County, NY	
	Niagara County, NY	0.9568
15500	Burlington, NC	
	Alamance County, NC	0.8747
15540	Burlington-South Burlington, VT	
	Chittenden County, VT	
	Franklin County, VT	
	Grand Isle County, VT	0.9660
15764	Cambridge-Newton-Framingham, MA	
	Middlesex County, MA	1.1215
15804	Camden, NJ	
	Burlington County, NJ	
	Camden County, NJ	
	Gloucester County, NJ	1.0411
15940	Canton-Massillon, OH	
	Carroll County, OH	
	Stark County, OH	0.8935
15980	Cape Coral-Fort Myers, FL	
	Lee County, FL	0.9396
16180	Carson City, NV	
	Carson City, NV	1.0003
16220	Casper, WY	
	Natrona County, WY	0.9385
16300	Cedar Rapids, IA	
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	0.8852

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
16580	Champaign-Urbana, IL	
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	0.9392
16620	Charleston, WV	
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	0.8289
16700	Charleston-North Charleston, SC	
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	0.9124
16740	Charlotte-Gastonia-Concord, NC-SC	
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	0.9520
16820	Charlottesville, VA	
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	0.9277
16860	Chattanooga, TN-GA	
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	0.8994
16940	Cheyenne, WY	
	Laramie County, WY	0.9308

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
16974	Chicago-Naperville-Joliet, IL	
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	1.0715
17020	Chico, CA	
	Butte County, CA	1.1290
17140	Cincinnati-Middletown, OH-KY-IN	
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	0.9784
17300	Clarksville, TN-KY	
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	0.8251
17420	Cleveland, TN	
	Bradley County, TN	
	Polk County, TN	0.8052
17460	Cleveland-Elyria-Mentor, OH	
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	0.9339
17660	Coeur d'Alene, ID	
	Kootenai County, ID	0.9532

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
17780	College Station-Bryan, TX	
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	0.9358
17820	Colorado Springs, CO	
	El Paso County, CO	
	Teller County, CO	0.9719
17860	Columbia, MO	
	Boone County, MO	
	Howard County, MO	0.8658
17900	Columbia, SC	
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	0.8800
17980	Columbus, GA-AL	
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	0.8729
18020	Columbus, IN	
	Bartholomew County, IN	0.9537
18140	Columbus, OH	
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	1.0085
18580	Corpus Christi, TX	
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	0.8588
18700	Corvallis, OR	
	Benton County, OR	1.0959
19060	Cumberland, MD-WV	
	Allegany County, MD	
	Mineral County, WV	0.8294

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
19124	Dallas-Plano-Irving, TX	
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	0.9915
19140	Dalton, GA	
	Murray County, GA	
	Whitfield County, GA	0.8760
19180	Danville, IL	
	Vermilion County, IL	0.8957
19260	Danville, VA	
	Pittsylvania County, VA	
	Danville City, VA	0.8240
19340	Davenport-Moline-Rock Island, IA-IL	
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	0.8830
19380	Dayton, OH	
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	0.9190
19460	Decatur, AL	
	Lawrence County, AL	
	Morgan County, AL	0.7885
19500	Decatur, IL	
	Macon County, IL	0.8074
19660	Deltona-Daytona Beach-Ormond Beach, FL	
	Volusia County, FL	0.9031

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
19740	Denver-Aurora, CO	
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	1.0718
19780	Des Moines,-West Des Moines, IA	
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	0.9226
19804	Detroit-Livonia-Dearborn, MI	
	Wayne County, MI	0.9999
20020	Dothan, AL	
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	0.7270
20100	Dover, DE	
	Kent County, DE	1.0099
20220	Dubuque, IA	
	Dubuque County, IA	0.9058
20260	Duluth, MN-WI	
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	0.9975
20500	Durham, NC	
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	0.9816
20740	Eau Claire, WI	
	Chippewa County, WI	
	Eau Claire County, WI	0.9475
20764	Edison, NJ	
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	1.1181

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
20940	El Centro, CA	
	Imperial County, CA	0.8914
21060	Elizabethtown, KY	
	Hardin County, KY	
	Larue County, KY	0.8711
21140	Elkhart-Goshen, IN	
	Elkhart County, IN	0.9611
21300	Elmira, NY	
	Chemung County, NY	0.8264
21340	El Paso, TX	
	El Paso County, TX	0.8989
21500	Erie, PA	
	Erie County, PA	0.8495
21660	Eugene-Springfield, OR	
	Lane County, OR	1.0932
21780	Evansville, IN-KY	
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	0.8662
21820	Fairbanks, AK	
	Fairbanks North Star Borough, AK	1.1050
21940	Fajardo, PR	
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	0.4375
	Fargo, ND-MN	
22020	Cass County, ND	
	Clay County, MN	0.8042
22140	Farmington, NM	
	San Juan County, NM	0.9587
22180	Fayetteville, NC	
	Cumberland County, NC	
	Hoke County, NC	0.9368
22220	Fayetteville-Springdale-Rogers, AR-MO	
	Benton County, AR	
	Madison County, AR	
	Washington County, AR	
	McDonald County, MO	0.8742
22380	Flagstaff, AZ	
	Coconino County, AZ	1.1687

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
22420	Flint, MI	
	Genesee County, MI	1.1220
22500	Florence, SC	
	Darlington County, SC	
	Florence County, SC	0.8249
22520	Florence-Muscle Shoals, AL	
	Colbert County, AL	
	Lauderdale County, AL	0.7680
22540	Fond du Lac, WI	
	Fond du Lac County, WI	0.9667
22660	Fort Collins-Loveland, CO	
	Larimer County, CO	0.9897
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	
	Broward County, FL	1.0229
22900	Fort Smith, AR-OK	
	Crawford County, AR	
	Franklin County, AR	
	Sebastian County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	0.7933
23020	Fort Walton Beach-Crestview-Destin, FL	
	Okaloosa County, FL	0.8743
23060	Fort Wayne, IN	
	Allen County, IN	
	Wells County, IN	
	Whitley County, IN	0.9284
23104	Fort Worth-Arlington, TX	
	Johnson County, TX	
	Parker County, TX	
	Tarrant County, TX	
	Wise County, TX	0.9693
23420	Fresno, CA	
	Fresno County, CA	1.0993
23460	Gadsden, AL	
	Etowah County, AL	0.8159
23540	Gainesville, FL	
	Alachua County, FL	
	Gilchrist County, FL	0.9196
23580	Gainesville, GA	
	Hall County, GA	0.9216

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9224
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8256
24140	Goldsboro, NC Wayne County, NC	0.9288
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7881
24300	Grand Junction, CO Mesa County, CO	0.9864
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9315
24500	Great Falls, MT Cascade County, MT	0.8675
24540	Greeley, CO Weld County, CO	0.9658
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9727
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9010
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9402
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9860
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3064

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
25060	Gulfport-Biloxi, MS	
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	0.8773
25180	Hagerstown-Martinsburg, MD-WV	
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	0.9013
25260	Hanford-Corcoran, CA	
	Kings County, CA	1.0499
25420	Harrisburg-Carlisle, PA	
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	0.9280
25500	Harrisonburg, VA	
	Rockingham County, VA	
	Harrisonburg City, VA	0.8867
25540	Hartford-West Hartford-East Hartford, CT	
	Hartford County, CT	
	Middlesex County, CT	
	Tolland County, CT	1.0959
25620	Hattiesburg, MS	
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	0.7366
25860	Hickory-Lenoir-Morganton, NC	
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	0.9028
	Hinesville-Fort Stewart, GA	
	Liberty County, GA	
25980	Long County, GA	0.9187
26100	Holland-Grand Haven, MI	
	Ottawa County, MI	0.9006
26180	Honolulu, HI	
	Honolulu County, HI	1.1556
26300	Hot Springs, AR	
	Garland County, AR	0.9109
26380	Houma-Bayou Cane-Thibodaux, LA	
	Lafourche Parish, LA	
	Terrebonne Parish, LA	0.7892

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
26420	Houston-Sugar Land-Baytown, TX	
	Austin County, TX	
	Brazoria County, TX	
	Chambers County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
	Waller County, TX	0.9939
26580	Huntington-Ashland, WV-KY-OH	
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	0.9041
26620	Huntsville, AL	
	Limestone County, AL	
	Madison County, AL	0.9146
26820	Idaho Falls, ID	
	Bonneville County, ID	
	Jefferson County, ID	0.9264
26900	Indianapolis-Carmel, IN	
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	0.9844
26980	Iowa City, IA	
	Johnson County, IA	
	Washington County, IA	0.9568
27060	Ithaca, NY	
	Tompkins County, NY	0.9630
27100	Jackson, MI	
	Jackson County, MI	0.9329

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
27140	Jackson, MS	
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	0.8011
27180	Jackson, TN	
	Chester County, TN	
	Madison County, TN	0.8676
27260	Jacksonville, FL	
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	0.9021
27340	Jacksonville, NC	
	Onslow County, NC	0.8079
27500	Janesville, WI	
	Rock County, WI	0.9702
27620	Jefferson City, MO	
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	0.8478
27740	Johnson City, TN	
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	0.7677
27780	Johnstown, PA	
	Cambria County, PA	0.7543
27860	Jonesboro, AR	
	Craighead County, AR	
	Poinsett County, AR	0.7790
27900	Joplin, MO	
	Jasper County, MO	
	Newton County, MO	0.8951
28020	Kalamazoo-Portage, MI	
	Kalamazoo County, MI	
	Van Buren County, MI	1.0433
28100	Kankakee-Bradley, IL	
	Kankakee County, IL	1.0238

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
28140	Kansas City, MO-KS	
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	0.9504
28420	Kennewick-Richland-Pasco, WA	
	Benton County, WA	
	Franklin County, WA	1.0075
28660	Killeen-Temple-Fort Hood, TX	
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	0.8249
28700	Kingsport-Bristol-Bristol, TN-VA	
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	0.7658
28740	Kingston, NY	
	Ulster County, NY	0.9556
28940	Knoxville, TN	
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	0.8036
29020	Kokomo, IN	
	Howard County, IN	
	Tipton County, IN	0.9591
29100	La Crosse, WI-MN	
	Houston County, MN	
	La Crosse County, WI	0.9685

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
29140	Lafayette, IN	
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	0.8869
29180	Lafayette, LA	
	Lafayette Parish, LA	
	St. Martin Parish, LA	0.8247
29340	Lake Charles, LA	
	Calcasieu Parish, LA	
	Cameron Parish, LA	0.7777
29404	Lake County-Kenosha County, IL-WI	
	Lake County, IL	
	Kenosha County, WI	1.0603
	Lake Havasu City-Kingman, AZ	
29420	Mohave County, AZ	0.9333
29460	Lakeland, FL	
	Polk County, FL	0.8661
29540	Lancaster, PA	
	Lancaster County, PA	0.9252
29620	Lansing-East Lansing, MI	
	Clinton County, MI	
	Eaton County, MI	
	Ingham County, MI	1.0119
29700	Laredo, TX	
	Webb County, TX	0.8093
29740	Las Cruces, NM	
	Dona Ana County, NM	0.8676
29820	Las Vegas-Paradise, NV	
	Clark County, NV	1.1799
29940	Lawrence, KS	
	Douglas County, KS	0.8227
30020	Lawton, OK	
	Comanche County, OK	0.8025
30140	Lebanon, PA	
	Lebanon County, PA	0.8192
30300	Lewiston, ID-WA	
	Nez Perce County, ID	
	Asotin County, WA	0.9454
30340	Lewiston-Auburn, ME	
	Androscoggin County, ME	0.9193

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
30460	Lexington-Fayette, KY	
	Bourbon County, KY	
	Clark County, KY	
	Fayette County, KY	
	Jessamine County, KY	
	Scott County, KY	
	Woodford County, KY	0.9191
30620	Lima, OH	
	Allen County, OH	0.9424
30700	Lincoln, NE	
	Lancaster County, NE	
	Seward County, NE	1.0051
30780	Little Rock-North Little Rock-Conway, AR	
	Faulkner County, AR	
	Grant County, AR	
	Lonoke County, AR	
	Perry County, AR	
	Pulaski County, AR	
	Saline County, AR	0.8863
30860	Logan, UT-ID	
	Franklin County, ID	
	Cache County, UT	0.9183
30980	Longview, TX	
	Gregg County, TX	
	Rusk County, TX	
	Upshur County, TX	0.8717
31020	Longview, WA	
	Cowlitz County, WA	1.0827
31084	Los Angeles-Long Beach-Glendale, CA	
	Los Angeles County, CA	1.1771
31140	Louisville-Jefferson County, KY-IN	
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Jefferson County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	0.9065

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
31180	Lubbock, TX	
	Crosby County, TX	
	Lubbock County, TX	0.8680
31340	Lynchburg, VA	
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	0.8732
31420	Macon, GA	
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	0.9541
31460	Madera, CA	
	Madera County, CA	0.8069
31540	Madison, WI	
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	1.0935
31700	Manchester-Nashua, NH	
	Hillsborough County, NH	1.0273
31900	Mansfield, OH	
	Richland County, OH	0.9271
32420	Mayagüez, PR	
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	0.3711
32580	McAllen-Edinburg-Mission, TX	
	Hidalgo County, TX	0.9123
32780	Medford, OR	
	Jackson County, OR	1.0318
32820	Memphis, TN-MS-AR	
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	0.9250
32900	Merced, CA	
	Merced County, CA	1.2120

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
33124	Miami-Miami Beach-Kendall, FL	
	Miami-Dade County, FL	1.0002
33140	Michigan City-La Porte, IN	
	LaPorte County, IN	0.8914
33260	Midland, TX	
	Midland County, TX	1.0017
33340	Milwaukee-Waukesha-West Allis, WI	
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	1.0214
33460	Minneapolis-St. Paul-Bloomington, MN-WI	
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	1.1093
33540	Missoula, MT	
	Missoula County, MT	0.8953
33660	Mobile, AL	
	Mobile County, AL	0.8033
33700	Modesto, CA	
	Stanislaus County, CA	1.1962
33740	Monroe, LA	
	Ouachita Parish, LA	
	Union Parish, LA	0.7832
33780	Monroe, MI	
	Monroe County, MI	0.9414
33860	Montgomery, AL	
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	0.8088
34060	Morgantown, WV	
	Monongalia County, WV	
	Preston County, WV	0.8321

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
34100	Morristown, TN	
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	0.7388
34580	Mount Vernon-Anacortes, WA	
	Skagit County, WA	1.0529
34620	Muncie, IN	
	Delaware County, IN	0.8214
34740	Muskegon-Norton Shores, MI	
	Muskegon County, MI	0.9836
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	
	Horry County, SC	0.8634
34900	Napa, CA	
	Napa County, CA	1.4476
34940	Naples-Marco Island, FL	
	Collier County, FL	0.9487
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	0.9689
35004	Nassau-Suffolk, NY	
	Nassau County, NY	
	Suffolk County, NY	1.2640
35084	Newark-Union, NJ-PA	
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	1.1862
35300	New Haven-Milford, CT	
	New Haven County, CT	1.1871

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
35380	New Orleans-Metairie-Kenner, LA	
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	0.8897
35644	New York-White Plains-Wayne, NY-NJ	
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
	Westchester County, NY	1.3115
35660	Niles-Benton Harbor, MI	
	Berrien County, MI	0.9141
35980	Norwich-New London, CT	
	New London County, CT	1.1432
36084	Oakland-Fremont-Hayward, CA	
	Alameda County, CA	
	Contra Costa County, CA	1.5685
36100	Ocala, FL	
	Marion County, FL	0.8627
36140	Ocean City, NJ	
	Cape May County, NJ	1.0988
36220	Odessa, TX	
	Ector County, TX	1.0042
36260	Ogden-Clearfield, UT	
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	0.9000

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
36420	Oklahoma City, OK	
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	0.8815
36500	Olympia, WA	
	Thurston County, WA	1.1512
36540	Omaha-Council Bluffs, NE-IA	
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	0.9561
36740	Orlando-Kissimmee, FL	
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	0.9226
36780	Oshkosh-Neenah, WI	
	Winnebago County, WI	0.9551
36980	Owensboro, KY	
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	0.8652
37100	Oxnard-Thousand Oaks-Ventura, CA	
	Ventura County, CA	1.1852
37340	Palm Bay-Melbourne-Titusville, FL	
	Brevard County, FL	0.9325
	Palm Coast, FL	
37380	Flager County, FL	0.8945
37460	Panama City-Lynn Haven, FL	
	Bay County, FL	0.8313
37620	Parkersburg-Marietta-Vienna, WV-OH	
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	0.8105

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
37700	Pascagoula, MS	
	George County, MS	
	Jackson County, MS	0.8647
	Peabody, MA	
37764	Essex County, MA	1.0650
37860	Pensacola-Ferry Pass-Brent, FL	
	Escambia County, FL	
	Santa Rosa County, FL	0.8281
37900	Peoria, IL	
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	0.9299
37964	Philadelphia, PA	
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	1.0925
38060	Phoenix-Mesa-Scottsdale, AZ	
	Maricopa County, AZ	
	Pinal County, AZ	1.0264
38220	Pine Bluff, AR	
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	0.7839
38300	Pittsburgh, PA	
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	0.8525
38340	Pittsfield, MA	
	Berkshire County, MA	1.0091
38540	Pocatello, ID	
	Bannock County, ID	
	Power County, ID	0.9465
38660	Ponce, PR	
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	0.4450

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
38860	Portland-South Portland-Biddeford, ME	
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	1.0042
38900	Portland-Vancouver-Beaverton, OR-WA	
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	1.1498
38940	Port St. Lucie, FL	
	Martin County, FL	
	St. Lucie County, FL	1.0016
39100	Poughkeepsie-Newburgh-Middletown, NY	
	Dutchess County, NY	
	Orange County, NY	1.0982
39140	Prescott, AZ	
	Yavapai County, AZ	1.0020
39300	Providence-New Bedford-Fall River, RI-MA	
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	1.0574
39340	Provo-Orem, UT	
	Juab County, UT	
	Utah County, UT	0.9557
39380	Pueblo, CO	
	Pueblo County, CO	0.8851
39460	Punta Gorda, FL	
	Charlotte County, FL	0.9254
39540	Racine, WI	
	Racine County, WI	0.9498
39580	Raleigh-Cary, NC	
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	0.9839
39660	Rapid City, SD	
	Meade County, SD	
	Pennington County, SD	0.8811

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
39740	Reading, PA	
	Berks County, PA	0.9356
39820	Redding, CA	
	Shasta County, CA	1.3541
39900	Reno-Sparks, NV	
	Storey County, NV	
	Washoe County, NV	1.0715
40060	Richmond, VA	
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	0.9425
40140	Riverside-San Bernardino-Ontario, CA	
	Riverside County, CA	
	San Bernardino County, CA	1.1100
40220	Roanoke, VA	
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	0.8691
40340	Rochester, MN	
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	1.0755

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
40380	Rochester, NY	
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	0.8858
40420	Rockford, IL	
	Boone County, IL	
	Winnebago County, IL	0.9814
40484	Rockingham County-Strafford County, NH	
	Rockingham County, NH	
	Strafford County, NH	1.0111
40580	Rocky Mount, NC	
	Edgecombe County, NC	
	Nash County, NC	0.9001
40660	Rome, GA	
	Floyd County, GA	0.9042
40900	Sacramento--Arden-Arcade--Roseville, CA	
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	1.3505
40980	Saginaw-Saginaw Township North, MI	
	Saginaw County, MI	0.8812
41060	St. Cloud, MN	
	Benton County, MN	
	Stearns County, MN	1.0549
41100	St. George, UT	
	Washington County, UT	0.9358
41140	St. Joseph, MO-KS	
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	0.8762

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
41180	St. Louis, MO-IL	
	Bond County, IL	
	Calhoun County, IL	
	Clinton County, IL	
	Jersey County, IL	
	Macoupin County, IL	
	Madison County, IL	
	Monroe County, IL	
	St. Clair County, IL	
	Crawford County, MO	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO	
	Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	0.9024
41420	Salem, OR	
	Marion County, OR	
	Polk County, OR	1.0572
41500	Salinas, CA	
	Monterey County, CA	1.4775
41540	Salisbury, MD	
	Somerset County, MD	
	Wicomico County, MD	0.8994
41620	Salt Lake City, UT	
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	0.9399
41660	San Angelo, TX	
	Irion County, TX	
	Tom Green County, TX	0.8579
41700	San Antonio, TX	
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	0.8834
41740	San Diego-Carlsbad-San Marcos, CA	
	San Diego County, CA	1.1492

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
41780	Sandusky, OH	
	Erie County, OH	0.8822
41884	San Francisco-San Mateo-Redwood City, CA	
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	1.5195
41900	San Germán-Cabo Rojo, PR	
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	0.4729
41940	San Jose-Sunnyvale-Santa Clara, CA	
	San Benito County, CA	
	Santa Clara County, CA	1.5735

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
41980	San Juan-Caguas-Guaynabo, PR	
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	0.4528
42020	San Luis Obispo-Paso Robles, CA	
	San Luis Obispo County, CA	1.2488

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
42044	Santa Ana-Anaheim-Irvine, CA	
	Orange County, CA	1.1766
42060	Santa Barbara-Santa Maria-Goleta, CA	
	Santa Barbara County, CA	1.1714
42100	Santa Cruz-Watsonville, CA	
	Santa Cruz County, CA	1.6122
42140	Santa Fe, NM	
	Santa Fe County, NM	1.0734
42220	Santa Rosa-Petaluma, CA	
	Sonoma County, CA	1.4696
42260	Sarasota-Bradenton-Venice, FL	
	Manatee County, FL	
	Sarasota County, FL	0.9933
42340	Savannah, GA	
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	0.9131
42540	Scranton--Wilkes-Barre, PA	
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	0.8457
42644	Seattle-Bellevue-Everett, WA	
	King County, WA	
	Snohomish County, WA	1.1572
42680	Sebastian-Vero Beach, FL	
	Indian River County, FL	0.9412
43100	Sheboygan, WI	
	Sheboygan County, WI	0.8975
43300	Sherman-Denison, TX	
	Grayson County, TX	0.8320
43340	Shreveport-Bossier City, LA	
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	0.8476
43580	Sioux City, IA-NE-SD	
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	0.9251
43620	Sioux Falls, SD	
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	0.9563

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
43780	South Bend-Mishawaka, IN-MI	
	St. Joseph County, IN	
	Cass County, MI	0.9617
43900	Spartanburg, SC	
	Spartanburg County, SC	0.9422
44060	Spokane, WA	
	Spokane County, WA	1.0455
44100	Springfield, IL	
	Menard County, IL	
	Sangamon County, IL	0.8944
44140	Springfield, MA	
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	1.0366
44180	Springfield, MO	
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	0.8695
44220	Springfield, OH	
	Clark County, OH	0.8694
44300	State College, PA	
	Centre County, PA	0.8768
44700	Stockton, CA	
	San Joaquin County, CA	1.1855
44940	Sumter, SC	
	Sumter County, SC	0.8599
45060	Syracuse, NY	
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	0.9910
45104	Tacoma, WA	
	Pierce County, WA	1.1055
45220	Tallahassee, FL	
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	0.9025
45300	Tampa-St. Petersburg-Clearwater, FL	
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	0.9020

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
45460	Terre Haute, IN	
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	0.8805
45500	Texarkana, TX-Texarkana, AR	
	Miller County, AR	
	Bowie County, TX	0.7770
45780	Toledo, OH	
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	0.9431
45820	Topeka, KS	
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	0.8538
45940	Trenton-Ewing, NJ	
	Mercer County, NJ	1.0699
46060	Tucson, AZ	
	Pima County, AZ	0.9245
46140	Tulsa, OK	
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	0.8340
46220	Tuscaloosa, AL	
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	0.8303
46340	Tyler, TX	
	Smith County, TX	0.9114
46540	Utica-Rome, NY	
	Herkimer County, NY	
	Oneida County, NY	0.8486

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
46660	Valdosta, GA	
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	0.8098
46700	Vallejo-Fairfield, CA	
	Solano County, CA	1.4666
47020	Victoria, TX	
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	0.8302
47220	Vineland-Millville-Bridgeton, NJ	
	Cumberland County, NJ	1.0133
47260	Virginia Beach-Norfolk-Newport News, VA-NC	
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	0.8818
47300	Visalia-Porterville, CA	
	Tulare County, CA	1.0091
47380	Waco, TX	
	McLennan County, TX	0.8518
47580	Warner Robins, GA	
	Houston County, GA	0.9128
47644	Warren-Troy-Farmington Hills, MI	
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	1.0001

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0855
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8519
48140	Wausau, WI Marathon County, WI	0.9679
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7924
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	1.1469
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9728
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6961

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
48620	Wichita, KS	
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	0.9062
48660	Wichita Falls, TX	
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	0.7920
48700	Williamsport, PA	
	Lycoming County, PA	0.8043
48864	Wilmington, DE-MD-NJ	
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	1.0824
48900	Wilmington, NC	
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	0.9410
49020	Winchester, VA-WV	
	Frederick County, VA	
	Winchester City, VA	
	Hampshire County, WV	0.9913
49180	Winston-Salem, NC	
	Davie County, NC	
	Forsyth County, NC	
	Stokes County, NC	
	Yadkin County, NC	0.9118
49340	Worcester, MA	
	Worcester County, MA	1.1287
49420	Yakima, WA	
	Yakima County, WA	1.0267
49500	Yauco, PR	
	Guánica Municipio, PR	
	Guayanilla Municipio, PR	
	Peñuelas Municipio, PR	
	Yauco Municipio, PR	0.3284
49620	York-Hanover, PA	
	York County, PA	0.9359
49660	Youngstown-Warren-Boardman, OH-PA	
	Mahoning County, OH	
	Trumbull County, OH	
	Mercer County, PA	0.9002

CBSA Code	Urban Area (Constituent Counties)	Proposed Wage Index
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.0756
49740	Yuma, AZ Yuma County, AZ	0.9488

TABLE 2: LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH September 30, 2009

CBSA Code	Nonurban Area	Proposed Wage Index
01	Alabama	0.7533
02	Alaska	1.2109
03	Arizona	0.8479
04	Arkansas	0.7371
05	California	1.2023
06	Colorado	0.9704
07	Connecticut	1.1119
08	Delaware	0.9727
10	Florida	0.8465
11	Georgia	0.7659
12	Hawaii	1.0612
13	Idaho	0.7920
14	Illinois	0.8335
15	Indiana	0.8576
16	Iowa	0.8566
17	Kansas	0.7981
18	Kentucky	0.7793
19	Louisiana	0.7373
20	Maine	0.8476
21	Maryland	0.9034
22	Massachusetts	1.1589
23	Michigan	0.8953
24	Minnesota	0.9079
25	Mississippi	0.7700
26	Missouri	0.7930
27	Montana	0.8379
28	Nebraska	0.8849
29	Nevada	0.9272
30	New Hampshire	1.0470
31	New Jersey*	------

CBSA Code	Nonurban Area	Proposed Wage Index
32	New Mexico	0.8940
33	New York	0.8268
34	North Carolina	0.8603
35	North Dakota	0.7182
36	Ohio	0.8714
37	Oklahoma	0.7492
38	Oregon	0.9906
39	Pennsylvania	0.8385
41	Rhode Island*	------
42	South Carolina	0.8656
43	South Dakota	0.8549
44	Tennessee	0.7723
45	Texas	0.7968
46	Utah	0.8116
47	Vermont	0.9919
49	Virginia	0.7896
50	Washington	1.0259
51	West Virginia	0.7454
52	Wisconsin	0.9667
53	Wyoming	0.9287

* All counties within the State are classified as urban.

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

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
001	Heart transplant or implant of heart assist system w MCC	0.0000	0.0	0.0
002	Heart transplant or implant of heart assist system w/o MCC	0.0000	0.0	0.0
003	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	4.2380	64.3	53.6
004	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	3.0249	46.7	38.9
005	Liver transplant w MCC or intestinal transplant	0.0000	0.0	0.0
006	Liver transplant w/o MCC	0.0000	0.0	0.0
007	Lung transplant	0.0000	0.0	0.0
008	Simultaneous pancreas/kidney transplant	0.0000	0.0	0.0
009	Bone marrow transplant	1.1417	29.0	24.2
010	Pancreas transplant	1.1417	29.0	24.2
011	Tracheostomy for face, mouth & neck diagnoses w MCC	1.5545	35.2	29.3

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
012	Tracheostomy for face, mouth & neck diagnoses w CC	1.5545	35.2	29.3
013	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC	1.5545	35.2	29.3
020	Intracranial vascular procedures w PDX hemorrhage w MCC	1.5545	35.2	29.3
021	Intracranial vascular procedures w PDX hemorrhage w CC	0.5472	20.3	16.9
022	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	0.5472	20.3	16.9
023	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant	1.5545	35.2	29.3
024	Cranio w major dev impl/acute complex CNS PDX w/o MCC	0.5472	20.3	16.9
025	Craniotomy & endovascular intracranial procedures w MCC	1.5545	35.2	29.3
026	Craniotomy & endovascular intracranial procedures w CC	1.5545	35.2	29.3
027	Craniotomy & endovascular intracranial procedures w/o CC/MCC	1.5545	35.2	29.3
028	Spinal procedures w MCC	1.1417	29.0	24.2
029	Spinal procedures w CC or spinal neurostimulators	1.1417	29.0	24.2
030	Spinal procedures w/o CC/MCC	0.5472	20.3	16.9
031	Ventricular shunt procedures w MCC	1.5545	35.2	29.3
032	Ventricular shunt procedures w CC	0.5472	20.3	16.9
033	Ventricular shunt procedures w/o CC/MCC	0.5472	20.3	16.9
034	Carotid artery stent procedure w MCC	1.5545	35.2	29.3
035	Carotid artery stent procedure w CC	1.1417	29.0	24.2
036	Carotid artery stent procedure w/o CC/MCC	1.1417	29.0	24.2
037	Extracranial procedures w MCC	1.5545	35.2	29.3
038	Extracranial procedures w CC	1.1417	29.0	24.2
039	Extracranial procedures w/o CC/MCC	1.1417	29.0	24.2
040	Periph/cranial nerve & other nerv syst proc w MCC	1.2704	36.2	30.2
041	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim	1.0810	34.3	28.6
042	Periph/cranial nerve & other nerv syst proc w/o CC/MCC	0.7305	22.9	19.1
052	Spinal disorders & injuries w CC/MCC	1.0629	32.3	26.9
053	Spinal disorders & injuries w/o CC/MCC	1.0629	32.3	26.9
054	Nervous system neoplasms w MCC	0.7205	23.6	19.7
055	Nervous system neoplasms w/o MCC	0.6779	22.0	18.3
056	Degenerative nervous system disorders w MCC	0.7407	26.4	22.0
057	Degenerative nervous system disorders w/o MCC	0.6309	24.4	20.3
058	Multiple sclerosis & cerebellar ataxia w MCC	0.7305	22.9	19.1
059	Multiple sclerosis & cerebellar ataxia w CC	0.5595	22.6	18.8
060	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	0.5472	20.3	16.9
061	Acute ischemic stroke w use of thrombolytic agent w MCC	0.7897	24.2	20.2
062	Acute ischemic stroke w use of thrombolytic agent w CC	0.6563	22.7	18.9
063	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	0.5472	20.3	16.9
064	Intracranial hemorrhage or cerebral infarction w MCC	0.7746	25.1	20.9

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
065	Intracranial hemorrhage or cerebral infarction w CC	0.6691	23.3	19.4
066	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	0.5472	20.3	16.9
067	Nonspecific cva & precerebral occlusion w/o infarct w MCC	0.5472	20.3	16.9
068	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	0.5472	20.3	16.9
069	Transient ischemia	0.5472	20.3	16.9
070	Nonspecific cerebrovascular disorders w MCC	0.7897	24.2	20.2
071	Nonspecific cerebrovascular disorders w CC	0.6563	22.7	18.9
072	Nonspecific cerebrovascular disorders w/o CC/MCC	0.5472	20.3	16.9
073	Cranial & peripheral nerve disorders w MCC	0.7849	25.6	21.3
074	Cranial & peripheral nerve disorders w/o MCC	0.6260	23.4	19.5
075	Viral meningitis w CC/MCC	0.7305	22.9	19.1
076	Viral meningitis w/o CC/MCC	0.5472	20.3	16.9
077	Hypertensive encephalopathy w MCC	0.7305	22.9	19.1
078	Hypertensive encephalopathy w CC	0.7305	22.9	19.1
079	Hypertensive encephalopathy w/o CC/MCC	0.5472	20.3	16.9
080	Nontraumatic stupor & coma w MCC	0.6312	24.6	20.5
081	Nontraumatic stupor & coma w/o MCC	0.5618	23.1	19.3
082	Traumatic stupor & coma, coma >1 hr w MCC	0.8864	29.5	24.6
083	Traumatic stupor & coma, coma >1 hr w CC	0.7305	22.9	19.1
084	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	0.7305	22.9	19.1
085	Traumatic stupor & coma, coma <1 hr w MCC	0.9044	28.3	23.6
086	Traumatic stupor & coma, coma <1 hr w CC	0.7437	25.1	20.9
087	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	0.6361	20.4	17.0
088	Concussion w MCC	1.1417	29.0	24.2
089	Concussion w CC	1.1417	29.0	24.2
090	Concussion w/o CC/MCC	1.1417	29.0	24.2
091	Other disorders of nervous system w MCC	0.8019	25.6	21.3
092	Other disorders of nervous system w CC	0.6704	22.0	18.3
093	Other disorders of nervous system w/o CC/MCC	0.5811	20.1	16.8
094	Bacterial & tuberculous infections of nervous system w MCC	1.0328	27.9	23.3
095	Bacterial & tuberculous infections of nervous system w CC	0.9306	27.0	22.5
096	Bacterial & tuberculous infections of nervous system w/o CC/MCC	0.9306	27.0	22.5
097	Non-bacterial infect of nervous sys exc viral meningitis w MCC	0.9289	26.8	22.3
098	Non-bacterial infect of nervous sys exc viral meningitis w CC	0.8629	22.7	18.9
099	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	0.7305	22.9	19.1
100	Seizures w MCC	0.7904	26.5	22.1
101	Seizures w/o MCC	0.6177	21.4	17.8
102	Headaches w MCC	0.8249	25.0	20.8
103	Headaches w/o MCC	0.8249	25.0	20.8
113	Orbital procedures w CC/MCC	0.7305	22.9	19.1
114	Orbital procedures w/o CC/MCC	0.7305	22.9	19.1

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
115	Extraocular procedures except orbit	0.8249	25.0	20.8
116	Intraocular procedures w CC/MCC	0.8249	25.0	20.8
117	Intraocular procedures w/o CC/MCC	0.8249	25.0	20.8
121	Acute major eye infections w CC/MCC	0.7305	22.9	19.1
122	Acute major eye infections w/o CC/MCC	0.5472	20.3	16.9
123	Neurological eye disorders	0.5472	20.3	16.9
124	Other disorders of the eye w MCC	1.1417	29.0	24.2
125	Other disorders of the eye w/o MCC	0.8249	25.0	20.8
129	Major head & neck procedures w CC/MCC or major device	1.1977	26.4	22.0
130	Major head & neck procedures w/o CC/MCC	0.7305	22.9	19.1
131	Cranial/facial procedures w CC/MCC	1.5545	35.2	29.3
132	Cranial/facial procedures w/o CC/MCC	1.5545	35.2	29.3
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	0.7305	22.9	19.1
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0.7305	22.9	19.1
135	Sinus & mastoid procedures w CC/MCC	0.7305	22.9	19.1
136	Sinus & mastoid procedures w/o CC/MCC	0.7305	22.9	19.1
137	Mouth procedures w CC/MCC	1.5545	35.2	29.3
138	Mouth procedures w/o CC/MCC	1.5545	35.2	29.3
139	Salivary gland procedures	1.5545	35.2	29.3
146	Ear, nose, mouth & throat malignancy w MCC	1.1977	26.4	22.0
147	Ear, nose, mouth & throat malignancy w CC	1.0416	24.9	20.8
148	Ear, nose, mouth & throat malignancy w/o CC/MCC	0.7305	22.9	19.1
149	Dysequilibrium	0.5472	20.3	16.9
150	Epistaxis w MCC	0.7305	22.9	19.1
151	Epistaxis w/o MCC	0.7305	22.9	19.1
152	Otitis media & URI w MCC	0.7305	22.9	19.1
153	Otitis media & URI w/o MCC	0.7305	22.9	19.1
154	Nasal trauma & deformity w MCC	0.7703	21.0	17.5
155	Nasal trauma & deformity w CC	0.7703	21.0	17.5
156	Nasal trauma & deformity w/o CC/MCC	0.7305	22.9	19.1
157	Dental & Oral Diseases w MCC	0.8249	25.0	20.8
158	Dental & Oral Diseases w CC	0.8249	25.0	20.8
159	Dental & Oral Diseases w/o CC/MCC	0.5472	20.3	16.9
163	Major chest procedures w MCC	2.2157	39.7	33.1
164	Major chest procedures w CC	1.5545	35.2	29.3
165	Major chest procedures w/o CC/MCC	1.5545	35.2	29.3
166	Other resp system O.R. procedures w MCC	2.4392	42.3	35.3
167	Other resp system O.R. procedures w CC	2.1594	38.0	31.7
168	Other resp system O.R. procedures w/o CC/MCC	1.1417	29.0	24.2
175	Pulmonary embolism w MCC	0.7160	22.0	18.3
176	Pulmonary embolism w/o MCC	0.5989	20.1	16.8
177	Respiratory infections & inflammations w MCC	0.8393	23.5	19.6
178	Respiratory infections & inflammations w CC	0.7671	22.2	18.5
179	Respiratory infections & inflammations w/o CC/MCC	0.6885	19.0	15.8
180	Respiratory neoplasms w MCC	0.8140	20.2	16.8
181	Respiratory neoplasms w CC	0.7103	19.3	16.1
182	Respiratory neoplasms w/o CC/MCC	0.5472	20.3	16.9

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
183	Major chest trauma w MCC	0.5472	20.3	16.9
184	Major chest trauma w CC	0.5472	20.3	16.9
185	Major chest trauma w/o CC/MCC	0.5472	20.3	16.9
186	Pleural effusion w MCC	0.8259	23.6	19.7
187	Pleural effusion w CC	0.7042	21.1	17.6
188	Pleural effusion w/o CC/MCC	0.7042	21.1	17.6
189	Pulmonary edema & respiratory failure	0.9743	24.0	20.0
190	Chronic obstructive pulmonary disease w MCC	0.6858	20.9	17.4
191	Chronic obstructive pulmonary disease w CC	0.6256	19.5	16.3
192	Chronic obstructive pulmonary disease w/o CC/MCC	0.5832	17.2	14.3
193	Simple pneumonia & pleurisy w MCC	0.7088	21.6	18.0
194	Simple pneumonia & pleurisy w CC	0.6429	19.8	16.5
195	Simple pneumonia & pleurisy w/o CC/MCC	0.5962	18.2	15.2
196	Interstitial lung disease w MCC	0.6529	20.0	16.7
197	Interstitial lung disease w CC	0.6133	19.6	16.3
198	Interstitial lung disease w/o CC/MCC	0.5956	19.7	16.4
199	Pneumothorax w MCC	0.8249	25.0	20.8
200	Pneumothorax w CC	0.7305	22.9	19.1
201	Pneumothorax w/o CC/MCC	0.5472	20.3	16.9
202	Bronchitis & asthma w CC/MCC	0.6903	21.1	17.6
203	Bronchitis & asthma w/o CC/MCC	0.5650	17.1	14.3
204	Respiratory signs & symptoms	0.8187	22.0	18.3
205	Other respiratory system diagnoses w MCC	0.8207	22.4	18.7
206	Other respiratory system diagnoses w/o MCC	0.7667	21.5	17.9
207	Respiratory system diagnosis w ventilator support 96+ hours	2.0266	34.3	28.6
208	Respiratory system diagnosis w ventilator support <96 hours	1.5514	27.8	23.2
215	Other heart assist system implant	0.8249	25.0	20.8
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	1.5545	35.2	29.3
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	0.8249	25.0	20.8
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	0.8249	25.0	20.8
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	1.5545	35.2	29.3
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	0.8249	25.0	20.8
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	0.8249	25.0	20.8
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	1.5545	35.2	29.3
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	1.5545	35.2	29.3
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	1.5545	35.2	29.3
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	1.5545	35.2	29.3
226	Cardiac defibrillator implant w/o cardiac cath w MCC	1.5545	35.2	29.3

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	1.5545	35.2	29.3
228	Other cardiothoracic procedures w MCC	1.5410	35.0	29.2
229	Other cardiothoracic procedures w CC	1.2681	30.8	25.7
230	Other cardiothoracic procedures w/o CC/MCC	0.8249	25.0	20.8
231	Coronary bypass w PTCA w MCC	1.5545	35.2	29.3
232	Coronary bypass w PTCA w/o MCC	0.8249	25.0	20.8
233	Coronary bypass w cardiac cath w MCC	1.5545	35.2	29.3
234	Coronary bypass w cardiac cath w/o MCC	0.8249	25.0	20.8
235	Coronary bypass w/o cardiac cath w MCC	1.5545	35.2	29.3
236	Coronary bypass w/o cardiac cath w/o MCC	0.8249	25.0	20.8
237	Major cardiovasc procedures w MCC or thoracic aortic anuerysm repair	1.5545	35.2	29.3
238	Major cardiovasc procedures w/o MCC	0.8249	25.0	20.8
239	Amputation for circ sys disorders exc upper limb & toe w MCC	1.3794	37.4	31.2
240	Amputation for circ sys disorders exc upper limb & toe w CC	1.2872	36.1	30.1
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	1.1417	29.0	24.2
242	Permanent cardiac pacemaker implant w MCC	1.5545	35.2	29.3
243	Permanent cardiac pacemaker implant w CC	1.5545	35.2	29.3
244	Permanent cardiac pacemaker implant w/o CC/MCC	1.1417	29.0	24.2
245	AICD lead & generator procedures	0.7305	22.9	19.1
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	0.8249	25.0	20.8
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	0.8249	25.0	20.8
248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	1.5545	35.2	29.3
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	1.5545	35.2	29.3
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	0.8249	25.0	20.8
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	0.8249	25.0	20.8
252	Other vascular procedures w MCC	1.5410	35.0	29.2
253	Other vascular procedures w CC	1.2681	30.8	25.7
254	Other vascular procedures w/o CC/MCC	0.8249	25.0	20.8
255	Upper limb & toe amputation for circ system disorders w MCC	1.1713	33.7	28.1
256	Upper limb & toe amputation for circ system disorders w CC	0.9516	29.4	24.5
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC	0.9516	29.4	24.5
258	Cardiac pacemaker device replacement w MCC	1.5545	35.2	29.3
259	Cardiac pacemaker device replacement w/o MCC	1.5545	35.2	29.3
260	Cardiac pacemaker revision except device replacement w MCC	1.5545	35.2	29.3
261	Cardiac pacemaker revision except device replacement w CC	0.5472	20.3	16.9
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	0.5472	20.3	16.9

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
263	Vein ligation & stripping	0.8249	25.0	20.8
264	Other circulatory system O.R. procedures	1.0667	31.6	26.3
280	Acute myocardial infarction, discharged alive w MCC	0.7263	21.4	17.8
281	Acute myocardial infarction, discharged alive w CC	0.6931	22.8	19.0
282	Acute myocardia infarction, discharged alive w/o CC/MCC	0.6931	22.8	19.0
283	Acute myocardial infarction, expired w MCC	0.6609	17.0	14.2
284	Acute myocardial infarction, expired w CC	0.6609	17.0	14.2
285	Acute myocardial infarction, expired w/o CC/MCC	0.6609	17.0	14.2
286	Circulatory disorders except AMI, w card cath w MCC	1.1417	29.0	24.2
287	Circulatory disorders except AMI, w card cath w/o MCC	0.8249	25.0	20.8
288	Acute & subacute endocarditis w MCC	0.9082	26.4	22.0
289	Acute & subacute endocarditis w CC	0.8580	26.4	22.0
290	Acute & subacute endocarditis w/o CC/MCC	0.7664	25.5	21.3
291	Heart failure & shock w MCC	0.6968	21.4	17.8
292	Heart failure & shock w CC	0.6252	20.4	17.0
293	Heart failure & shock w/o CC/MCC	0.5775	18.5	15.4
294	Deep vein thrombophlebitis w CC/MCC	0.8249	25.0	20.8
295	Deep vein thrombophlebitis w/o CC/MCC	0.8249	25.0	20.8
296	Cardiac arrest, unexplained w MCC	0.6609	17.0	14.2
297	Cardiac arrest, unexplained w CC	0.6609	17.0	14.2
298	Cardiac arrest, unexplained w/o CC/MCC	0.6609	17.0	14.2
299	Peripheral vascular disorders w MCC	0.7152	24.8	20.7
300	Peripheral vascular disorders w CC	0.6150	22.2	18.5
301	Peripheral vascular disorders w/o CC/MCC	0.5557	19.4	16.2
302	Atherosclerosis w MCC	0.6170	21.9	18.3
303	Atherosclerosis w/o MCC	0.5673	20.5	17.1
304	Hypertension w MCC	0.8249	25.0	20.8
305	Hypertension w/o MCC	0.5856	22.6	18.8
306	Cardiac congenital & valvular disorders w MCC	0.8786	24.2	20.2
307	Cardiac congenital & valvular disorders w/o MCC	0.7767	23.1	19.3
308	Cardiac arrhythmia & conduction disorders w MCC	0.7431	24.7	20.6
309	Cardiac arrhythmia & conduction disorders w CC	0.5940	20.4	17.0
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5184	17.0	14.2
311	Angina pectoris	0.7305	22.9	19.1
312	Syncope & collapse	0.5336	19.7	16.4
313	Chest pain	0.5472	20.3	16.9
314	Other circulatory system diagnoses w MCC	0.8123	23.1	19.3
315	Other circulatory system diagnoses w CC	0.7114	21.6	18.0
316	Other circulatory system diagnoses w/o CC/MCC	0.6243	18.9	15.8
326	Stomach, esophageal & duodenal proc w MCC	1.8646	36.2	30.2
327	Stomach, esophageal & duodenal proc w CC	1.5545	35.2	29.3
328	Stomach, esophageal & duodenal proc w/o CC/MCC	0.5472	20.3	16.9
329	Major small & large bowel procedures w MCC	1.5545	35.2	29.3
330	Major small & large bowel procedures w CC	1.5545	35.2	29.3
331	Major small & large bowel procedures w/o CC/MCC	0.5472	20.3	16.9
332	Rectal resection w MCC	1.5057	36.1	30.1
333	Rectal resection w CC	1.3309	30.7	25.6
334	Rectal resection w/o CC/MCC	0.8249	25.0	20.8
335	Peritoneal adhesiolysis w MCC	1.5545	35.2	29.3

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
336	Peritoneal adhesiolysis w CC	0.7305	22.9	19.1
337	Peritoneal adhesiolysis w/o CC/MCC	0.7305	22.9	19.1
338	Appendectomy w complicated principal diag w MCC	0.8884	24.1	20.1
339	Appendectomy w complicated principal diag w CC	0.7667	22.2	18.5
340	Appendectomy w complicated principal diag w/o CC/MCC	0.6856	19.9	16.6
341	Appendectomy w/o complicated principal diag w MCC	0.8884	24.1	20.1
342	Appendectomy w/o complicated principal diag w CC	0.7667	22.2	18.5
343	Appendectomy w/o complicated principal diag w/o CC/MCC	0.6856	19.9	16.6
344	Minor small & large bowel procedures w MCC	0.8884	24.1	20.1
345	Minor small & large bowel procedures w CC	0.7667	22.2	18.5
346	Minor small & large bowel procedures w/o CC/MCC	0.6856	19.9	16.6
347	Anal & stomal procedures w MCC	1.1417	29.0	24.2
348	Anal & stomal procedures w CC	0.8249	25.0	20.8
349	Anal & stomal procedures w/o CC/MCC	0.5472	20.3	16.9
350	Inguinal & femoral hernia procedures w MCC	1.5545	35.2	29.3
351	Inguinal & femoral hernia procedures w CC	1.1417	29.0	24.2
352	Inguinal & femoral hernia procedures w/o CC/MCC	0.8249	25.0	20.8
353	Hernia procedures except inguinal & femoral w MCC	0.8249	25.0	20.8
354	Hernia procedures except inguinal & femoral w CC	0.8249	25.0	20.8
355	Hernia procedures except inguinal & femoral w/o CC/MCC	0.8249	25.0	20.8
356	Other digestive system O.R. procedures w MCC	1.5057	36.1	30.1
357	Other digestive system O.R. procedures w CC	1.3309	30.7	25.6
358	Other digestive system O.R. procedures w/o CC/MCC	0.8249	25.0	20.8
368	Major esophageal disorders w MCC	1.1417	29.0	24.2
369	Major esophageal disorders w CC	1.1417	29.0	24.2
370	Major esophageal disorders w/o CC/MCC	1.1417	29.0	24.2
371	Major gastrointestinal disorders & peritoneal infections w MCC	0.8884	24.1	20.1
372	Major gastrointestinal disorders & peritoneal infections w CC	0.7667	22.2	18.5
373	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	0.6856	19.9	16.6
374	Digestive malignancy w MCC	0.8340	22.9	19.1
375	Digestive malignancy w CC	0.7563	19.7	16.4
376	Digestive malignancy w/o CC/MCC	0.5472	20.3	16.9
377	G.I. hemorrhage w MCC	0.7032	22.5	18.8
378	G.I. hemorrhage w CC	0.6334	21.5	17.9
379	G.I. hemorrhage w/o CC/MCC	0.5472	20.3	16.9
380	Complicated peptic ulcer w MCC	0.8249	25.0	20.8
381	Complicated peptic ulcer w CC	0.8249	25.0	20.8
382	Complicated peptic ulcer w/o CC/MCC	0.7305	22.9	19.1
383	Uncomplicated peptic ulcer w MCC	0.8249	25.0	20.8
384	Uncomplicated peptic ulcer w/o MCC	0.7305	22.9	19.1
385	Inflammatory bowel disease w MCC	0.8874	24.6	20.5
386	Inflammatory bowel disease w CC	0.7655	22.9	19.1
387	Inflammatory bowel disease w/o CC/MCC	0.7655	22.9	19.1
388	G.I. obstruction w MCC	0.8967	22.8	19.0

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
389	G.I. obstruction w CC	0.7893	21.9	18.3
390	G.I. obstruction w/o CC/MCC	0.7893	21.9	18.3
391	Esophagitis, gastroent & misc digest disorders w MCC	0.8509	24.4	20.3
392	Esophagitis, gastroent & misc digest disorders w/o MCC	0.6943	20.4	17.0
393	Other digestive system diagnoses w MCC	0.9915	25.5	21.3
394	Other digestive system diagnoses w CC	0.8523	22.0	18.3
395	Other digestive system diagnoses w/o CC/MCC	0.7214	20.9	17.4
405	Pancreas, liver & shunt procedures w MCC	1.5545	35.2	29.3
406	Pancreas, liver & shunt procedures w CC	1.5545	35.2	29.3
407	Pancreas, liver & shunt procedures w/o CC/MCC	1.1417	29.0	24.2
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	1.5545	35.2	29.3
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	1.5545	35.2	29.3
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	1.5545	35.2	29.3
411	Cholecystectomy w c.d.e. w MCC	1.1417	29.0	24.2
412	Cholecystectomy w c.d.e. w CC	1.1417	29.0	24.2
413	Cholecystectomy w c.d.e. w/o CC/MCC	1.1417	29.0	24.2
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	1.1417	29.0	24.2
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC	1.1417	29.0	24.2
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	1.1417	29.0	24.2
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC	1.5545	35.2	29.3
418	Laparoscopic cholecystectomy w/o c.d.e. w CC	1.1417	29.0	24.2
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	1.1417	29.0	24.2
420	Hepatobiliary diagnostic procedures w MCC	1.1417	29.0	24.2
421	Hepatobiliary diagnostic procedures w CC	0.8249	25.0	20.8
422	Hepatobiliary diagnostic procedures w/o CC/MCC	0.8249	25.0	20.8
423	Other hepatobiliary or pancreas O.R. procedures w MCC	1.1417	29.0	24.2
424	Other hepatobiliary or pancreas O.R. procedures w CC	0.8249	25.0	20.8
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	0.8249	25.0	20.8
432	Cirrhosis & alcoholic hepatitis w MCC	0.6223	19.0	15.8
433	Cirrhosis & alcoholic hepatitis w CC	0.6223	19.0	15.8
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0.5472	20.3	16.9
435	Malignancy of hepatobiliary system or pancreas w MCC	0.7422	20.2	16.8
436	Malignancy of hepatobiliary system or pancreas w CC	0.7086	19.6	16.3
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	0.7086	19.6	16.3
438	Disorders of pancreas except malignancy w MCC	1.0057	24.3	20.3
439	Disorders of pancreas except malignancy w CC	0.8437	21.9	18.3
440	Disorders of pancreas except malignancy w/o CC/MCC	0.7204	18.8	15.7
441	Disorders of liver except malig,cirr,alc hepa w MCC	0.7588	21.8	18.2
442	Disorders of liver except malig,cirr,alc hepa w CC	0.6925	21.2	17.7
443	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	0.6925	21.2	17.7
444	Disorders of the biliary tract w MCC	0.8181	24.0	20.0
445	Disorders of the biliary tract w CC	0.6977	21.7	18.1

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
446	Disorders of the biliary tract w/o CC/MCC	0.5472	20.3	16.9
453	Combined anterior/posterior spinal fusion w MCC	1.5545	35.2	29.3
454	Combined anterior/posterior spinal fusion w CC	1.5545	35.2	29.3
455	Combined anterior/posterior spinal fusion w/o CC/MCC	1.5545	35.2	29.3
456	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC	1.5545	35.2	29.3
457	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC	1.5545	35.2	29.3
458	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC	1.5545	35.2	29.3
459	Spinal fusion except cervical w MCC	1.5545	35.2	29.3
460	Spinal fusion except cervical w/o MCC	1.5545	35.2	29.3
461	Bilateral or multiple major joint procs of lower extremity w MCC	1.5545	35.2	29.3
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	1.1417	29.0	24.2
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	1.3514	38.8	32.3
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	1.1906	36.3	30.3
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	1.0747	29.6	24.7
466	Revision of hip or knee replacement w MCC	1.5545	35.2	29.3
467	Revision of hip or knee replacement w CC	1.5545	35.2	29.3
468	Revision of hip or knee replacement w/o CC/MCC	1.5545	35.2	29.3
469	Major joint replacement or reattachment of lower extremity w MCC	1.5545	35.2	29.3
470	Major joint replacement or reattachment of lower extremity w/o MCC	1.5545	35.2	29.3
471	Cervical spinal fusion w MCC	1.5545	35.2	29.3
472	Cervical spinal fusion w CC	1.5545	35.2	29.3
473	Cervical spinal fusion w/o CC/MCC	1.5545	35.2	29.3
474	Amputation for musculoskeletal sys & conn tissue dis w MCC	1.3338	36.6	30.5
475	Amputation for musculoskeletal sys & conn tissue dis w CC	1.1390	32.7	27.3
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	1.1390	32.7	27.3
477	Biopsies of musculoskeletal system & connective tissue w MCC	1.5545	35.2	29.3
478	Biopsies of musculoskeletal system & connective tissue w CC	1.1417	29.0	24.2
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	1.1417	29.0	24.2
480	Hip & femur procedures except major joint w MCC	1.5545	35.2	29.3
481	Hip & femur procedures except major joint w CC	1.5545	35.2	29.3
482	Hip & femur procedures except major joint w/o CC/MCC	1.1417	29.0	24.2
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	1.5545	35.2	29.3

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	1.1417	29.0	24.2
485	Knee procedures w pdx of infection w MCC	1.5545	35.2	29.3
486	Knee procedures w pdx of infection w CC	1.1417	29.0	24.2
487	Knee procedures w pdx of infection w/o CC/MCC	1.1417	29.0	24.2
488	Knee procedures w/o pdx of infection w CC/MCC	1.5545	35.2	29.3
489	Knee procedures w/o pdx of infection w/o CC/MCC	1.5545	35.2	29.3
490	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim	1.1417	29.0	24.2
491	Back & neck proc exc spinal fusion w/o CC/MCC	1.1417	29.0	24.2
492	Lower extrem & humer proc except hip,foot,femur w MCC	1.5545	35.2	29.3
493	Lower extrem & humer proc except hip,foot,femur w CC	1.1417	29.0	24.2
494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	0.8249	25.0	20.8
495	Local excision & removal int fix devices exc hip & femur w MCC	1.3650	38.1	31.8
496	Local excision & removal int fix devices exc hip & femur w CC	1.1981	36.8	30.7
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	1.1417	29.0	24.2
498	Local excision & removal int fix devices of hip & femur w CC/MCC	1.5545	35.2	29.3
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC	0.7305	22.9	19.1
500	Soft tissue procedures w MCC	1.3212	35.2	29.3
501	Soft tissue procedures w CC	1.2903	30.7	25.6
502	Soft tissue procedures w/o CC/MCC	0.8249	25.0	20.8
503	Foot procedures w MCC	1.1417	29.0	24.2
504	Foot procedures w CC	0.8249	25.0	20.8
505	Foot procedures w/o CC/MCC	0.5472	20.3	16.9
506	Major thumb or joint procedures	0.7305	22.9	19.1
507	Major shoulder or elbow joint procedures w CC/MCC	0.8249	25.0	20.8
508	Major shoulder or elbow joint procedures w/o CC/MCC	0.8249	25.0	20.8
509	Arthroscopy	0.5472	20.3	16.9
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	1.1417	29.0	24.2
511	Shoulder,elbow or forearm proc,exc major joint proc w CC	1.1417	29.0	24.2
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	0.5472	20.3	16.9
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC	1.5545	35.2	29.3
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	0.7305	22.9	19.1
515	Other musculoskelet sys & conn tiss O.R. proc w MCC	1.3230	34.8	29.0
516	Other musculoskelet sys & conn tiss O.R. proc w CC	1.1417	29.0	24.2
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	0.8249	25.0	20.8
533	Fractures of femur w MCC	0.8249	25.0	20.8

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
534	Fractures of femur w/o MCC	0.7305	22.9	19.1
535	Fractures of hip & pelvis w MCC	0.7305	22.9	19.1
536	Fractures of hip & pelvis w/o MCC	0.5998	23.7	19.8
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	0.5472	20.3	16.9
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0.5472	20.3	16.9
539	Osteomyelitis w MCC	0.9013	29.7	24.8
540	Osteomyelitis w CC	0.8107	28.7	23.9
541	Osteomyelitis w/o CC/MCC	0.7787	26.9	22.4
542	Pathological fractures & musculoskelet & conn tiss malig w MCC	0.7359	21.7	18.1
543	Pathological fractures & musculoskelet & conn tiss malig w CC	0.6347	21.3	17.8
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	0.5472	20.3	16.9
545	Connective tissue disorders w MCC	0.8501	23.9	19.9
546	Connective tissue disorders w CC	0.6492	20.7	17.3
547	Connective tissue disorders w/o CC/MCC	0.5472	20.3	16.9
548	Septic arthritis w MCC	0.8584	28.2	23.5
549	Septic arthritis w CC	0.7347	26.4	22.0
550	Septic arthritis w/o CC/MCC	0.6704	23.5	19.6
551	Medical back problems w MCC	0.7305	26.6	22.2
552	Medical back problems w/o MCC	0.6022	22.8	19.0
553	Bone diseases & arthropathies w MCC	0.8249	25.0	20.8
554	Bone diseases & arthropathies w/o MCC	0.4822	20.5	17.1
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC	0.7305	22.9	19.1
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	0.7305	22.9	19.1
557	Tendonitis, myositis & bursitis w MCC	0.8177	25.9	21.6
558	Tendonitis, myositis & bursitis w/o MCC	0.6919	21.4	17.8
559	Aftercare, musculoskeletal system & connective tissue w MCC	0.7157	26.2	21.8
560	Aftercare, musculoskeletal system & connective tissue w CC	0.6393	24.6	20.5
561	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	0.5889	21.7	18.1
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	1.1417	29.0	24.2
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	0.5472	20.3	16.9
564	Other musculoskeletal sys & connective tissue diagnoses w MCC	0.8134	24.9	20.8
565	Other musculoskeletal sys & connective tissue diagnoses w CC	0.7382	24.8	20.7
566	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	0.6862	22.1	18.4
573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	1.3068	38.0	31.7
574	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1.1567	37.1	30.9

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
575	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	0.9938	31.7	26.4
576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	1.5545	35.2	29.3
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	1.1417	29.0	24.2
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	0.7305	22.9	19.1
579	Other skin, subcut tiss & breast proc w MCC	1.2793	36.8	30.7
580	Other skin, subcut tiss & breast proc w CC	1.1001	34.8	29.0
581	Other skin, subcut tiss & breast proc w/o CC/MCC	0.9100	29.9	24.9
582	Mastectomy for malignancy w CC/MCC	1.5545	35.2	29.3
583	Mastectomy for malignancy w/o CC/MCC	1.5545	35.2	29.3
584	Breast biopsy, local excision & other breast procedures w CC/MCC	1.1417	29.0	24.2
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	1.1417	29.0	24.2
592	Skin ulcers w MCC	0.8875	27.1	22.6
593	Skin ulcers w CC	0.7877	26.8	22.3
594	Skin ulcers w/o CC/MCC	0.7342	24.3	20.3
595	Major skin disorders w MCC	0.7525	24.5	20.4
596	Major skin disorders w/o MCC	0.6155	23.8	19.8
597	Malignant breast disorders w MCC	0.8249	25.0	20.8
598	Malignant breast disorders w CC	0.7305	22.9	19.1
599	Malignant breast disorders w/o CC/MCC	0.7305	22.9	19.1
600	Non-malignant breast disorders w CC/MCC	0.7305	22.9	19.1
601	Non-malignant breast disorders w/o CC/MCC	0.7305	22.9	19.1
602	Cellulitis w MCC	0.6643	22.5	18.8
603	Cellulitis w/o MCC	0.5528	19.4	16.2
604	Trauma to the skin, subcut tiss & breast w MCC	0.8249	25.0	20.8
605	Trauma to the skin, subcut tiss & breast w/o MCC	0.5685	21.2	17.7
606	Minor skin disorders w MCC	0.8324	23.2	19.3
607	Minor skin disorders w/o MCC	0.6776	22.6	18.8
614	Adrenal & pituitary procedures w CC/MCC	1.2008	33.1	27.6
615	Adrenal & pituitary procedures w/o CC/MCC	0.7305	22.9	19.1
616	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	1.4505	41.0	34.2
617	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	1.2414	33.3	27.8
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	0.8249	25.0	20.8
619	O.R. procedures for obesity w MCC	0.8249	25.0	20.8
620	O.R. procedures for obesity w CC	0.8249	25.0	20.8
621	O.R. procedures for obesity w/o CC/MCC	0.8249	25.0	20.8
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	1.1462	35.6	29.7
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	1.0197	32.2	26.8
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	0.8249	25.0	20.8

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
625	Thyroid, parathyroid & thyroglossal procedures w MCC	1.3385	36.6	30.5
626	Thyroid, parathyroid & thyroglossal procedures w CC	1.2008	33.1	27.6
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0.7305	22.9	19.1
628	Other endocrine, nutrit & metab O.R. proc w MCC	1.3385	36.6	30.5
629	Other endocrine, nutrit & metab O.R. proc w CC	1.2008	33.1	27.6
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	0.7305	22.9	19.1
637	Diabetes w MCC	0.7726	25.8	21.5
638	Diabetes w CC	0.6757	24.0	20.0
639	Diabetes w/o CC/MCC	0.6064	20.6	17.2
640	Nutritional & misc metabolic disorders w MCC	0.7879	23.2	19.3
641	Nutritional & misc metabolic disorders w/o MCC	0.6889	22.0	18.3
642	Inborn errors of metabolism	0.7305	22.9	19.1
643	Endocrine disorders w MCC	0.7358	24.9	20.8
644	Endocrine disorders w CC	0.7358	24.9	20.8
645	Endocrine disorders w/o CC/MCC	0.5472	20.3	16.9
652	Kidney transplant	0.0000	0.0	0.0
653	Major bladder procedures w MCC	1.1417	29.0	24.2
654	Major bladder procedures w CC	0.7305	22.9	19.1
655	Major bladder procedures w/o CC/MCC	0.5472	20.3	16.9
656	Kidney & ureter procedures for neoplasm w MCC	0.8249	25.0	20.8
657	Kidney & ureter procedures forneoplasm w CC	0.8249	25.0	20.8
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	0.8249	25.0	20.8
659	Kidney & ureter procedures for non-neoplasm w MCC	1.1417	29.0	24.2
660	Kidney & ureter procedures for non-neoplasm w CC	0.7305	22.9	19.1
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	0.5472	20.3	16.9
662	Minor bladder procedures w MCC	0.8249	25.0	20.8
663	Minor bladder procedures w CC	0.8249	25.0	20.8
664	Minor bladder procedures w/o CC/MCC	1.5545	35.2	29.3
665	Prostatectomy w MCC	0.8249	25.0	20.8
666	Prostatectomy w CC	0.8249	25.0	20.8
667	Prostatectomy w/o CC/MCC	1.1417	29.0	24.2
668	Transurethral procedures w MCC	1.5545	35.2	29.3
669	Transurethral procedures w CC	1.5545	35.2	29.3
670	Transurethral procedures w/o CC/MCC	0.8249	25.0	20.8
671	Urethral procedures w CC/MCC	0.7305	22.9	19.1
672	Urethral procedures w/o CC/MCC	0.5472	20.3	16.9
673	Other kidney & urinary tract procedures w MCC	1.3255	33.6	28.0
674	Other kidney & urinary tract procedures w CC	1.2557	30.6	25.5
675	Other kidney & urinary tract procedures w/o CC/MCC	1.1417	29.0	24.2
682	Renal failure w MCC	0.8553	23.6	19.7
683	Renal failure w CC	0.7752	21.8	18.2
684	Renal failure w/o CC/MCC	0.7121	20.5	17.1
685	Admit for renal dialysis	0.7726	26.0	21.7
686	Kidney & urinary tract neoplasms w MCC	0.8933	23.6	19.7
687	Kidney & urinary tract neoplasms w CC	0.7305	22.9	19.1
688	Kidney & urinary tract neoplasms w/o CC/MCC	0.5472	20.3	16.9
689	Kidney & urinary tract infections w MCC	0.6624	22.9	19.1
690	Kidney & urinary tract infections w/o MCC	0.5655	20.2	16.8

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
691	Urinary stones w esw lithotripsy w CC/MCC	1.5545	35.2	29.3
692	Urinary stones w esw lithotripsy w/o CC/MCC	1.5545	35.2	29.3
693	Urinary stones w/o esw lithotripsy w MCC	0.7305	22.9	19.1
694	Urinary stones w/o esw lithotripsy w/o MCC	0.7305	22.9	19.1
695	Kidney & urinary tract signs & symptoms w MCC	0.8249	25.0	20.8
696	Kidney & urinary tract signs & symptoms w/o MCC	0.5472	20.3	16.9
697	Urethral stricture	0.5472	20.3	16.9
698	Other kidney & urinary tract diagnoses w MCC	0.7919	22.6	18.8
699	Other kidney & urinary tract diagnoses w CC	0.7293	22.1	18.4
700	Other kidney & urinary tract diagnoses w/o CC/MCC	0.6052	19.6	16.3
707	Major male pelvic procedures w CC/MCC	0.7305	22.9	19.1
708	Major male pelvic procedures w/o CC/MCC	0.5472	20.3	16.9
709	Penis procedures w CC/MCC	1.1417	29.0	24.2
710	Penis procedures w/o CC/MCC	1.1417	29.0	24.2
711	Testes procedures w CC/MCC	1.1417	29.0	24.2
712	Testes procedures w/o CC/MCC	1.1417	29.0	24.2
713	Transurethral prostatectomy w CC/MCC	1.5545	35.2	29.3
714	Transurethral prostatectomy w/o CC/MCC	0.5472	20.3	16.9
715	Other male reproductive system O.R. proc for malignancy w CC/MCC	1.5545	35.2	29.3
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	1.5545	35.2	29.3
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC	1.1417	29.0	24.2
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	0.5472	20.3	16.9
722	Malignancy, male reproductive system w MCC	0.8249	25.0	20.8
723	Malignancy, male reproductive system w CC	0.7305	22.9	19.1
724	Malignancy, male reproductive system w/o CC/MCC	0.5472	20.3	16.9
725	Benign prostatic hypertrophy w MCC	1.1417	29.0	24.2
726	Benign prostatic hypertrophy w/o MCC	0.5472	20.3	16.9
727	Inflammation of the male reproductive system w MCC	0.7754	25.9	21.6
728	Inflammation of the male reproductive system w/o MCC	0.6172	20.8	17.3
729	Other male reproductive system diagnoses w CC/MCC	1.0319	26.6	22.2
730	Other male reproductive system diagnoses w/o CC/MCC	0.7305	22.9	19.1
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	1.1417	29.0	24.2
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	0.5472	20.3	16.9
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	1.1417	29.0	24.2
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	0.8249	25.0	20.8
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	0.5472	20.3	16.9
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	1.1417	29.0	24.2
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	0.8249	25.0	20.8
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	0.5472	20.3	16.9

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
742	Uterine & adnexa proc for non-malignancy w CC/MCC	0.8249	25.0	20.8
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	0.5472	20.3	16.9
744	D&C, conization, laparascopy & tubal interruption w CC/MCC	0.8249	25.0	20.8
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	0.8249	25.0	20.8
746	Vagina, cervix & vulva procedures w CC/MCC	0.8249	25.0	20.8
747	Vagina, cervix & vulva procedures w/o CC/MCC	0.8249	25.0	20.8
748	Female reproductive system reconstructive procedures	0.8249	25.0	20.8
749	Other female reproductive system O.R. procedures w CC/MCC	0.8249	25.0	20.8
750	Other female reproductive system O.R. procedures w/o CC/MCC	0.8249	25.0	20.8
754	Malignancy, female reproductive system w MCC	1.1417	29.0	24.2
755	Malignancy, female reproductive system w CC	0.8249	25.0	20.8
756	Malignancy, female reproductive system w/o CC/MCC	0.5472	20.3	16.9
757	Infections, female reproductive system w MCC	0.8375	22.6	18.8
758	Infections, female reproductive system w CC	0.8317	27.2	22.7
759	Infections, female reproductive system w/o CC/MCC	0.5472	20.3	16.9
760	Menstrual & other female reproductive system disorders w CC/MCC	1.1417	29.0	24.2
761	Menstrual & other female reproductive system disorders w/o CC/MCC	0.5472	20.3	16.9
765	Cesarean section w CC/MCC	0.8249	25.0	20.8
766	Cesarean section w/o CC/MCC	0.7305	22.9	19.1
767	Vaginal delivery w sterilization &/or D&C	0.7305	22.9	19.1
768	Vaginal delivery w O.R. proc except steril &/or D&C	0.7305	22.9	19.1
769	Postpartum & post abortion diagnoses w O.R. procedure	0.7305	22.9	19.1
770	Abortion w D&C, aspiration curettage or hysterotomy	0.7305	22.9	19.1
774	Vaginal delivery w complicating diagnoses	0.7305	22.9	19.1
775	Vaginal delivery w/o complicating diagnoses	0.7305	22.9	19.1
776	Postpartum & post abortion diagnoses w/o O.R. procedure	1.1417	29.0	24.2
777	Ectopic pregnancy	0.7305	22.9	19.1
778	Threatened abortion	0.5472	20.3	16.9
779	Abortion w/o D&C	0.5472	20.3	16.9
780	False labor	0.5472	20.3	16.9
781	Other antepartum diagnoses w medical complications	1.1417	29.0	24.2
782	Other antepartum diagnoses w/o medical complications	0.5472	20.3	16.9
789	Neonates, died or transferred to another acute care facility	0.5472	20.3	16.9
790	Extreme immaturity or respiratory distress syndrome, neonate	0.5472	20.3	16.9
791	Prematurity w major problems	1.1417	29.0	24.2
792	Prematurity w/o major problems	0.5472	20.3	16.9
793	Full term neonate w major problems	1.1417	29.0	24.2
794	Neonate w other significant problems	1.1417	29.0	24.2
795	Normal newborn	0.5472	20.3	16.9
799	Splenectomy w MCC	1.1417	29.0	24.2
800	Splenectomy w CC	0.8249	25.0	20.8

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
801	Splenectomy w/o CC/MCC	0.8249	25.0	20.8
802	Other O.R. proc of the blood & blood forming organs w MCC	1.5545	35.2	29.3
803	Other O.R. proc of the blood & blood forming organs w CC	0.7305	22.9	19.1
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	0.7305	22.9	19.1
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	0.8009	20.7	17.3
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC	0.8009	20.7	17.3
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	0.8009	20.7	17.3
811	Red blood cell disorders w MCC	0.6655	23.2	19.3
812	Red blood cell disorders w/o MCC	0.5699	19.5	16.3
813	Coagulation disorders	0.8015	21.5	17.9
814	Reticuloendothelial & immunity disorders w MCC	0.7474	22.6	18.8
815	Reticuloendothelial & immunity disorders w CC	0.7305	22.9	19.1
816	Reticuloendothelial & immunity disorders w/o CC/MCC	0.7305	22.9	19.1
820	Lymphoma & leukemia w major O.R. procedure w MCC	0.8249	25.0	20.8
821	Lymphoma & leukemia w major O.R. procedure w CC	0.8249	25.0	20.8
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	0.8249	25.0	20.8
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC	1.1417	29.0	24.2
824	Lymphoma & non-acute leukemia w other O.R. proc w CC	1.1417	29.0	24.2
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	0.5472	20.3	16.9
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	0.8249	25.0	20.8
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	0.8249	25.0	20.8
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	0.8249	25.0	20.8
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	1.5545	35.2	29.3
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	1.5545	35.2	29.3
834	Acute leukemia w/o major O.R. procedure w MCC	1.1417	29.0	24.2
835	Acute leukemia w/o major O.R. procedure w CC	0.8249	25.0	20.8
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC	0.5472	20.3	16.9
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	1.5545	35.2	29.3
838	Chemo w acute leukemia as sdx w CC or high dose chemo agent	0.8249	25.0	20.8
839	Chemo w acute leukemia as sdx w/o CC/MCC	1.5545	35.2	29.3
840	Lymphoma & non-acute leukemia w MCC	0.8718	20.8	17.3
841	Lymphoma & non-acute leukemia w CC	0.8026	20.1	16.8
842	Lymphoma & non-acute leukemia w/o CC/MCC	0.7305	22.9	19.1

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
843	Other myeloprolif dis or poorly diff neopl diag w MCC	1.1417	29.0	24.2
844	Other myeloprolif dis or poorly diff neopl diag w CC	1.1417	29.0	24.2
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	1.1417	29.0	24.2
846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	1.6788	37.4	31.2
847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	1.4350	27.6	23.0
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	0.7305	22.9	19.1
849	Radiotherapy	0.8994	23.5	19.6
853	Infectious & parasitic diseases w O.R. procedure w MCC	1.7687	38.1	31.8
854	Infectious & parasitic diseases w O.R. procedure w CC	1.4381	30.8	25.7
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	0.7305	22.9	19.1
856	Postoperative or post-traumatic infections w O.R. proc w MCC	1.4470	36.1	30.1
857	Postoperative or post-traumatic infections w O.R. proc w CC	1.1886	31.5	26.3
858	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	1.1109	28.4	23.7
862	Postoperative & post-traumatic infections w MCC	0.8670	25.2	21.0
863	Postoperative & post-traumatic infections w/o MCC	0.7478	23.4	19.5
864	Fever of unknown origin	0.7305	22.9	19.1
865	Viral illness w MCC	0.7823	21.8	18.2
866	Viral illness w/o MCC	0.6431	21.2	17.7
867	Other infectious & parasitic diseases diagnoses w MCC	1.0954	23.6	19.7
868	Other infectious & parasitic diseases diagnoses w CC	0.8869	22.0	18.3
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC	0.5472	20.3	16.9
870	Septicemia w MV 96+ hours	1.9505	30.5	25.4
871	Septicemia w/o MV 96+ hours w MCC	0.8299	23.5	19.6
872	Septicemia w/o MV 96+ hours w/o MCC	0.7340	21.9	18.3
876	O.R. procedure w principal diagnoses of mental illness	0.7305	22.9	19.1
880	Acute adjustment reaction & psychosocial dysfunction	0.5472	20.3	16.9
881	Depressive neuroses	0.5472	20.3	16.9
882	Neuroses except depressive	0.5472	20.3	16.9
883	Disorders of personality & impulse control	0.5472	20.3	16.9
884	Organic disturbances & mental retardation	0.4883	23.3	19.4
885	Psychoses	0.4140	23.8	19.8
886	Behavioral & developmental disorders	0.5472	20.3	16.9
887	Other mental disorder diagnoses	0.5472	20.3	16.9
894	Alcohol/drug abuse or dependence, left ama	0.5472	20.3	16.9
895	Alcohol/drug abuse or dependence w rehabilitation therapy	0.5472	20.3	16.9
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.8249	25.0	20.8
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.5472	20.3	16.9
901	Wound debridements for injuries w MCC	1.3395	35.2	29.3

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
902	Wound debridements for injuries w CC	1.1605	33.5	27.9
903	Wound debridements for injuries w/o CC/MCC	0.7305	22.9	19.1
904	Skin grafts for injuries w CC/MCC	1.3351	40.8	34.0
905	Skin grafts for injuries w/o CC/MCC	0.7305	22.9	19.1
906	Hand procedures for injuries	0.5472	20.3	16.9
907	Other O.R. procedures for injuries w MCC	1.6622	36.8	30.7
908	Other O.R. procedures for injuries w CC	1.3966	34.1	28.4
909	Other O.R. procedures for injuries w/o CC/MCC	0.8249	25.0	20.8
913	Traumatic injury w MCC	0.8462	26.9	22.4
914	Traumatic injury w/o MCC	0.6448	21.9	18.3
915	Allergic reactions w MCC	0.5472	20.3	16.9
916	Allergic reactions w/o MCC	0.5472	20.3	16.9
917	Poisoning & toxic effects of drugs w MCC	0.7305	22.9	19.1
918	Poisoning & toxic effects of drugs w/o MCC	0.7305	22.9	19.1
919	Complications of treatment w MCC	0.9858	26.3	21.9
920	Complications of treatment w CC	0.8518	24.6	20.5
921	Complications of treatment w/o CC/MCC	0.7511	23.0	19.2
922	Other injury, poisoning & toxic effect diag w MCC	0.5472	20.3	16.9
923	Other injury, poisoning & toxic effect diag w/o MCC	0.5472	20.3	16.9
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	1.5545	35.2	29.3
928	Full thickness burn w skin graft or inhal inj w CC/MCC	1.1417	29.0	24.2
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC	0.7305	22.9	19.1
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	1.5545	35.2	29.3
934	Full thickness burn w/o skin grft or inhal inj	0.6998	24.2	20.2
935	Non-extensive burns	0.7525	24.9	20.8
939	O.R. proc w diagnoses of other contact w health services w MCC	1.2500	33.8	28.2
940	O.R. proc w diagnoses of other contact w health services w CC	1.1066	33.8	28.2
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	0.9719	28.8	24.0
945	Rehabilitation w CC/MCC	0.5867	22.2	18.5
946	Rehabilitation w/o CC/MCC	0.4935	18.9	15.8
947	Signs & symptoms w MCC	0.6340	22.7	18.9
948	Signs & symptoms w/o MCC	0.5642	23.4	19.5
949	Aftercare w CC/MCC	0.6693	22.1	18.4
950	Aftercare w/o CC/MCC	0.5735	18.5	15.4
951	Other factors influencing health status	1.5837	26.2	21.8
955	Craniotomy for multiple significant trauma	1.5545	35.2	29.3
956	Limb reattachment, hip & femur proc for multiple significant trauma	0.7305	22.9	19.1
957	Other O.R. procedures for multiple significant trauma w MCC	1.5545	35.2	29.3
958	Other O.R. procedures for multiple significant trauma w CC	1.1417	29.0	24.2
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	1.1417	29.0	24.2
963	Other multiple significant trauma w MCC	1.5545	35.2	29.3

MS-LTC-DRG	MS-LTC-DRG Title	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]
964	Other multiple significant trauma w CC	0.7305	22.9	19.1
965	Other multiple significant trauma w/o CC/MCC	0.5472	20.3	16.9
969	HIV w extensive O.R. procedure w MCC	1.5545	35.2	29.3
970	HIV w extensive O.R. procedure w/o MCC	1.5545	35.2	29.3
974	HIV w major related condition w MCC	0.8908	21.9	18.3
975	HIV w major related condition w CC	0.7492	21.3	17.8
976	HIV w major related condition w/o CC/MCC	0.7382	18.0	15.0
977	HIV w or w/o other related condition	0.7305	22.9	19.1
981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	2.2339	42.0	35.0
982	Extensive O.R. procedure unrelated to principal diagnosis w CC	1.8277	37.6	31.3
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.1417	29.0	24.2
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	1.5545	35.2	29.3
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC	1.1417	29.0	24.2
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.1417	29.0	24.2
987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	1.6972	37.9	31.6
988	Non-extensive O.R. proc unrelated to principal diagnosis w CC	1.3386	33.2	27.7
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	0.8249	25.0	20.8
998	Principal diagnosis invalid as discharge diagnosis	0.0000	0.0	0.0
999	Ungroupable	0.0000	0.0	0.0

[1]Transition blended relative weights for FY 2008 determined as described in Step 7 in section II.I.4. of the preamble of the FY 2008 IPPS final rule (72 FR 47295).
[2]The "short-stay outlier threshold" is calculated as 5/6ths of the geometric average length of stay of the MS-LTC-DRG (as specified at §412.529(a), in conjunction with §412.503).