DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, and 476

[CMS–1177–F]

RIN 0938–AK69

Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Implementation and FY 2003 Rates

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

ACTION: Final rule.

SUMMARY: This final rule establishes a prospective payment system for Medicare payment of inpatient hospital services furnished by long-term care hospitals (LTCHs) described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act). This final rule implements section 123 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 123 of the BBRA directs the Secretary to develop and implement a prospective payment system for LTCHs. The prospective payment system described in this final rule replaces the reasonable cost-based payment system under which LTCHs are currently paid.

EFFECTIVE DATE: The provisions of this final rule are effective on October 1, 2002.

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SUPPLEMENTARY INFORMATION:

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

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Acronyms

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

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

I. General Background

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. Section 223 of the Social Security Act Amendments of 1972 (Pub. L. 92–603) amended section 1861(v)(1) of the Social Security Act (the Act) to set forth limits on reasonable costs for hospital inpatient services. Section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–48) amended the Medicare statute to limit payment by placing a cap on allowable costs per discharge. Section 601 of the Social Security Amendments of 1983 (Pub. L. 98–21) added section 1886(d) to the Act that replaced the reasonable cost-based payment system for most hospital inpatient services. Section 1886(d) of the Act provides for a prospective payment system for the operating costs of acute care hospital inpatient stays, effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although most hospital inpatient services became subject to the acute care hospital inpatient prospective payment system, certain specialty hospitals are excluded from that system. These hospitals included long-term care hospitals (LTCHs), rehabilitation and psychiatric hospitals, rehabilitation and psychiatric units of acute care hospitals, and children's hospitals. Cancer hospitals were added to the list of excluded hospitals by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239).

Subsequent to the implementation of the acute care hospital inpatient prospective payment system, both the number of excluded hospitals and Medicare payments to these hospitals grew rapidly. Consequently, Congress enacted various provisions in the Balanced Budget Act (BBA) (Pub. L. 105–33), the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) to provide for the development and implementation of a prospective payment system for the following excluded hospitals:

- Rehabilitation hospitals (including units in acute care hospitals).
- Psychiatric hospitals (including units in acute care hospitals.
- LTCHs.

Section 4422 of the BBA mandated that the Secretary develop a legislative proposal, for presentation to the Congress by October 1, 1999, for a case-mix adjusted LTCH prospective payment system under the Medicare program. This system was to include an adequate patient classification system that reflects the differences in patient resource use and costs among LTCHs. Furthermore, in developing the legislative proposal for the prospective payment system, the Secretary was to consider several payment methodologies, including the feasibility of an expansion of the acute care hospital inpatient prospective payment system (diagnosis-related group (DRG) based system) established under section 1886(d) of the Act.

In the interim, section 4414 of the BBA imposed national limits (or caps) on hospital-specific target amounts (that is, the annual per discharge limit) for these excluded hospitals until cost reporting periods beginning on or after October 1, 2002. At the same time that the Congress modified the payment system based on limits on target amounts, it also included a provision in the BBA to require the Secretary to develop a legislative proposal for establishing a prospective payment system for LTCHs.

With the passage of the BBRA in November 1999, in section 122, the Congress refined some policies of the BBA before the implementation of the prospective payment systems for LTCHs and psychiatric hospitals and units. Section 123 of the BBRA further requires that the Secretary develop a per discharge, DRG-based system for LTCHs and requires that this system be described in a report to the Congress by

October 1, 2001, and be in place by October 1, 2002. Section 307(b)(1) of BIPA modified the BBRA's requirements for the prospective payment system for LTCHs by mandating that the Secretary'' * * * shall examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data.'' Furthermore, section 307(b)(1) of BIPA provided that the Secretary'' * * * shall examine and may provide for appropriate adjustments to the long-term hospital prospective payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment * * *.'' In the event that the Secretary is unable to implement the LTCH prospective payment system by October 1, 2002, section 307(b)(2) of BIPA requires the Secretary to implement a prospective payment system using the existing hospital DRGs, modified when feasible, to account for resource use by LTCHs.

(We note that, even though the LTCH prospective payment system in this final rule is effective for cost reporting periods that begin on or after October 1, 2002, we will not have computer system changes in place that are necessary to accommodate claims processing and payment under the prospective payment system until after January 1, 2003. As of October 16, 2002, a LTCH that is required to comply with the HIPAA Administrative Simplification Standards must submit electronic claims to the fiscal intermediary in compliance with 42 CFR 162.1002 and 45 CFR 162.1102, using the ICD–9-CM coding system, unless the LTCH obtains an extension in compliance with the Administrative Compliance Act (Pub. L. 107–105). Beginning October 16, 2003, LTCHs that obtained an extension and that are required to comply with the HIPAA Administrative Simplification Standards must start submitting electronic claims in compliance with the HIPPA regulations cited above, among others. We intend that, as of January 1, 2003, the fiscal intermediary will reconcile the payment amounts that have been made to LTCHs for all covered inpatient hospital services furnished to Medicare beneficiaries from cost reporting periods that begin on or after October 1, 2002 until the date of the systems implementation, with the amounts that are payable under the LTCH prospective payment methodology. Since LTCHs will receive payment under the LTCH prospective payment system at the start of their first cost reporting periods that begin on or after October 1, 2002, only those LTCHs with cost reporting periods starting October 1, 2002 until the date of the systems implementation will experience the payment reconciliation necessitated by this differential period. We also emphasize that the claims submission procedure of using ICD–9–CM codes will not change following the systems implementation of the LTCH prospective payment system. A detailed discussion on the operational procedures for this differential period appears in sections VIII.H. and X.N. of this final rule.)

II. Publication of Proposed Rulemaking

On March 22, 2002, we published a proposed rule in the **Federal Register** (67 FR 13416) that set forth the proposed Medicare prospective payment system for LTCHs as authorized under Public Law 106–113 and Public Law 106–554. In accordance with the requirements of section 123 of Public Law 106–113, as modified by section 307(b) of Public Law 106–554, we proposed to implement a prospective payment system for LTCHs to replace the current reasonable cost-based payment system under TEFRA. The proposed prospective payment system used information from LTCH patient records to classify patients into distinct DRGs based on clinical characteristics and expected resource needs. Separate payments would be calculated for each DRG with additional adjustments applied.

In the proposed rule and in this final rule, we discuss the development, policies, and implementation of the LTCH prospective payment system. These discussions in this final rule include the following:

- An overview of the current payment system for LTCHs (section III.).
- A discussion of the statutory requirements for developing and implementing a LTCH prospective payment system (section IV.).
- A discussion of research findings on LTCHs (section V.).
- A detailed discussion of the LTCH prospective payment system, including the patient classification system (section IX.), relative weights (section X.A.), payment rates (section X.B.), additional payments (section X.C.), and the budget-neutrality requirements (section X.F.) mandated by section 123 of Pub. L. 106–113.
- An analysis of the estimated impact of the LTCH prospective payment system on the Federal budget and LTCHs (section XII.).
- Changes to existing regulations and the establishment of regulations in 42 CFR Chapter IV to implement the LTCH prospective payment system.

We designed the prospective payment system for LTCHs with the following objectives:

- To base the prospective payment system on an analysis of the best information and data available.
- To establish a payment model using our experience in implementing other prospective payment systems.
- To provide incentives to control costs and to furnish services as efficiently as possible.
- To base payment on clinically coherent categories and to appropriately reflect average resource needs across different categories.
- To minimize opportunities and incentives for inappropriately maximizing Medicare payments.
- To establish a system that is beneficiary centered by formulating procedures for quality monitoring.
- To develop a system that is administratively feasible.

We received a total of 52 timely items of correspondence containing multiple comments on the proposed rule. The major issues addressed by the commenters included: the criteria for determining the 25-day average length of stay for LTCHs; payment adjustments for area wage differences; payments for special cases of short stays and interrupted stays; and data sources used to compute the prospective payments. Summaries of the public comments received and our responses to those comments are set forth below under the appropriate subject heading.

III. Overview of the Current Payment System for LTCHs

A. Exclusion of Certain Facilities From the Acute Care Hospital Inpatient Prospective Payment System

Although payment for operating costs of most hospital inpatient services became subject to a prospective payment system under the Social Security Amendments of 1983 (Pub. L. 98–21), which added section 1886(d) to the Act, certain types of hospitals and units were excluded from that payment system. Section 1886(d)(1)(B) of the Act lists the following classes of excluded hospitals:

- Psychiatric hospitals and units.
- Rehabilitation hospitals and units.
- LTCHs.
- Children's hospitals.

Effective with cost reporting periods beginning on or after October 1, 1989,

cancer hospitals were added to this list by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239).

The acute care hospital inpatient prospective payment system is a system of average-based payments that assumes that some patient stays will consume more resources than the typical stay, while others will demand fewer resources. Therefore, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the acute care hospital inpatient prospective payment system. In a report to the Congress, ''Hospital Prospective Payment for Medicare (1982),'' the Department of Health and Human Services stated that the ''467 DRGs were not designed to account for these types of treatment'' found in the four classes of excluded hospitals, and noted that ''including these hospitals will result in criticism and their application to these hospitals would be inaccurate and unfair.''

The Congress excluded these hospitals from the acute care hospital inpatient prospective payment system because they typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system. The legislative history of the 1983 Social Security Amendments stated that the ''DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays.'' (Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rept. No. 98–25, at 141 (1983)). Therefore, these hospitals could be systemically underpaid if the same DRG system were applied to them.

Following enactment in April 1983 of the Social Security Amendments of 1983, we implemented the acute care hospital inpatient prospective payment system on October 1, 1983, including the initial publication in the **Federal Register** of the rules and regulations for the acute care hospital inpatient prospective payment system: the September 1, 1983 interim final rule (48 FR 39752) and the January 3, 1984 final rule (49 FR 234). Updates and modifications of the regulations have been published annually in the **Federal Register**. We also developed payment policy for hospitals that were seeking to be excluded from the acute care hospital inpatient prospective payment system. The regulations concerning exclusion of LTCHs from the acute care hospital inpatient prospective payment system are found in 42 CFR Part 412, Subpart B.

B. Requirements for LTCHs to be Excluded From the Acute Care Hospital Inpatient Prospective Payment System

Under section 1886(d)(1)(B) of the Act, the prospective payment system for hospital inpatient operating costs set forth in section 1886(d) of the Act does not apply to several specified types of hospitals, including LTCHs, which are defined in section 1886(d)(1)(B)(iv)(I) of the Act as ''* * * a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.'' Section 4417(b)(1)(B) of the BBA added section 1886(d)(1)(B)(iv)(II) to the Act, which also provides another definition of LTCHs: specifically, a hospital that was first excluded in 1986 that has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis of neoplastic disease in the 12-month cost reporting period ending in FY 1997.

Implementing regulations at § 405.471(c)(5) (now § 412.23(e)) require the facility to have a provider agreement with Medicare to participate as a hospital, and an average inpatient length of stay greater than 25 days as calculated under the following formula: the average length of stay is calculated by dividing the total number of inpatient days (excluding leave of absence or pass days) for all patients by the total number of discharges for the hospital's most recent complete cost reporting period. The determination of whether or not a hospital qualifies as an LTCH is based on the hospital's most recently filed cost report, or if a change in the hospital's average length of stay is indicated, by the same method for the immediately preceding 6-month period (§ 412.23(e)(3)). (Requirements for hospitals seeking classification as LTCHs that have undergone a change in ownership, as described in § 489.18, are set forth in § 412.23(e)(3)(iii).)

C. Payment System Requirements Prior to the BBA

Hospitals that are excluded from the acute care hospital inpatient prospective payment system under section 1886(d)(1)(B) of the Act are paid for inpatient operating costs under the provisions of Public Law 97–248 (TEFRA) that are found in section 1886(b) of the Act and implemented in regulations at 42 CFR part 413. Public Law 97–248 established payments based on hospital-specific limits for inpatient operating costs. A ceiling on payments to hospitals excluded from the acute care hospital inpatient prospective payment system is determined by calculating the product of a facility's base year costs (the year on which its target reimbursement limit is based) per discharge, updated to the current year by a rate-of-increase percentage, and multiplied by the number of total current year discharges. (A detailed discussion of target amount payment limits under Public Law 97–248 can be found in the September 1, 1983 final rule published in the **Federal Register** (48 FR 39746).)

The base year for a facility varied, depending on when the facility was initially determined to be a prospective payment system-excluded provider. The base year for facilities that were established before the implementation of Public Law 97–248 was 1982, when Public Law 97–248 was enacted. For facilities established after implementation of Public Law 97–248 (section 1886(b) of the Act), we originally provided in the regulations for payment to these facilities for their full ''reasonable'' costs for their first 3 cost reporting years, and allowed the facilities to choose which of those years would be used in the future to determine their target limit. This ''new provider'' period was later shortened to 2 cost reporting years (§ 413.40(f)(1)(1992)), and we designated the second cost reporting year as the cost reporting year used to determine the hospital's per discharge target amount.

Excluded facilities whose costs were below their target amounts received bonus payments equal to the lesser of half of the difference between costs and the target amount, up to a maximum of 5 percent of the target amount, or the hospital's costs. For excluded facilities whose costs exceeded their target amounts, Medicare provided relief payments equal to half of the amount by which the hospital's costs exceeded the target amount up to 10 percent of the target amount. Excluded facilities that experienced a more significant increase in patient acuity could also apply for an additional amount under the regulations for Medicare exception payments (§ 413.40(d)).

D. Effects of the Current Payment System

Use of postacute care services has grown rapidly in recent years since the implementation of the acute care hospital inpatient prospective payment system. The average length of stay in acute care hospitals has decreased, and patients are increasingly being discharged to postacute care settings such as LTCHs, skilled nursing facilities

(SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs) to complete their course of treatment. The increased use of postacute care providers, including hospitals excluded from the acute care hospital inpatient prospective payment system, has resulted in the rapid growth in Medicare payments to these hospitals in recent years. In addition, there has been a significant increase in the number of LTCHs. In 1991, there were 91 LTCHs; in 1994, 155 LTCHs; in 1999, 225 LTCHs; in December 2000, 252 LTCHs; and in November 2001, 270 LTCHs. Payments to postacute care providers were among the fastest growing providers under the Medicare program throughout the 1990s. (Prospective Payment Assessment Commission (ProPAC) June 1996 Report to Congress, p. 91.)

LTCHs have experienced faster growth in the number of facilities and Medicare program payments than any other category of prospective payment system-excluded provider. In its June 1996 Report to Congress, ProPAC found that, from 1990 to 1993, payment to rehabilitation facilities rose about 25 percent per year, while payments to LTCHs increased 33 percent annually (p. 92). ProPAC also found that, from 1991 to 1995, the number of rehabilitation facilities increased 21 percent (from 852 in 1991 to 1,029 in 1995), while the number of LTCHs increased 93 percent (from 91 in 1991 to 176 in 1995) (p. 93). The best available Hospital Cost Report Information System (HCRIS) data indicate $398 million in payments for inpatient operating services to 105 LTCHs in FY 1993 and $1.05 billion in payments for inpatient operating services to 206 LTCHs in FY 1998. This amount represents more than a 96-percent increase in the number of LTCHs and a 164-percent increase in payments to LTCHs in 5 years.

In its March 1999 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) (formerly ProPAC) stated that: ''[The] TEFRA system has remained in effect longer than expected partly because of difficulties in accounting for the variation in resource use across patients in exempted facilities. The unintended consequences of sustaining that system have been a steady growth in the number of prospective payment system-exempt facilities and a substantial payment inequity between older and newer facilities. In particular, the payment system encouraged new exempt facilities to maximize their costs in the base year to establish high cost limits. Once subject to its relatively high limit, a recent entrant could reduce its costs below its limit, resulting in reimbursement of its full costs plus bonus payment. By contrast, facilities that existed before they became subject to TEFRA could not influence their cost limits. Given the relatively low limits of older facilities, they are more likely to incur costs above their limits and thus receive payments less than their costs.'' (p. 72)

To address concerns regarding the historical growth in payments and the disparity in payments to existing and newly excluded hospitals and units, the BBA mandated several changes to the existing payment system. These changes are outlined in section IV. of this preamble.

E. Research and Discussion of a Prospective Payment System for LTCHs Prior to the BBA

Section 603(a)(2)(C)(ii) of Public Law 98–21 required the Secretary to include the results of research studies on whether and how excluded hospitals and units can be paid on a prospective basis, in the 1985 Report to Congress on the Impact of Prospective Payment Methodology. HCFA (now CMS) undertook and funded a wide range of research projects that resulted in 1987 in a Report to Congress entitled ''Developing a Prospective Payment System for Excluded Hospitals.'' In that report, the Secretary presented an examination of the then current state of the four classes of excluded hospitals and units and offered recommendations for the development of a prospective payment system. ''Long-term'' or ''chronic disease'' hospitals, the report noted, ''are the least understood of the excluded hospital types'' (p. 3–51).

The following information was clear—there were a relatively small number of facilities (94 at that time); LTCHs were not dispersed throughout the country and, therefore, potential long-term care patients were receiving necessary care elsewhere; LTCHs, as generally defined by the greater than 25-day average length of stay, constituted a diverse set that closely resembled other hospitals, both included (acute care) and excluded (psychiatric, rehabilitation, and children's) under the acute care hospital inpatient prospective payment system (pp. 3–51 through 3–63). The Report concluded with the following discussion: ''Because this class of hospitals treats a very heterogeneous patient population and does not share a common set of facility characteristics, the development of a separate classification system for prospective payment purposes would appear to be both infeasible and undesirable. At the same time, as part of HCFA's [now CMS'] impact analysis, we were investigating the feasibility of including LTCHs under the current prospective payment system, where their cases would be expected to be paid predominantly under the prospective payment system outlier policy.'' (pp. 3–63 through 3–64)

The 1987 report further noted that present and future research on LTCHs would focus on acquiring a broader understanding of LTCHs, long-term care patients, and other treatment settings and on the preliminary financial impact of a prospective payment system on both LTCHs and the Medicare system. An initial inquiry was also planned ''into the role of those hospitals as a component of the continuum of care between acute care hospitals and skilled nursing facilities, as a general first step in developing a classification system for patients in these facilities * * *'' (p. 3–54).

ProPAC's March 1996 Report to Congress endorsed the concept of prospective payment systems for all postacute services, emphasizing consistent payment methods across all classes of facilities in order to encourage provider efficiency (p. 75). ProPAC's extensive analysis of ''patients using postacute care providers and in these providers' treatment patterns'' based on FY 1994 data discussed in the June 1996 Report to Congress, concluded that ''[a]lthough there was significant overlap in the hospital assigned DRGs across settings, other patient characteristics, such as medical complexity or functional status, may influence which patients use a particular site'' (p. 110).

In ProPAC's March 1, 1997 report, ProPAC's Recommendation 33, entitled ''Coordinating Post-Acute Care Provider Payment Methods,'' stated that ''the Commission urges the Congress and the Secretary to consider the overlap in services and beneficiaries across postacute care providers as they modify Medicare payment policies'' (p. 60).

The passage of Public Law 105–33 (the BBA) provided for the establishment of separate and distinct prospective payment systems for postacute care providers: SNFs (section 4432(a)), IRFs (section 4421), and HHAs (section 4603(b)). In addition, the Congress directed the Secretary to develop a legislative proposal to pay LTCHs prospectively as well (section 4422).

IV. Requirements of the BBA, BBRA, and BIPA for LTCHs

A. Provisions of the Current Payment System

1. BBA

The BBA amendments to section 1886(b) of the Act significantly altered the payment provisions for excluded hospitals and units and also added other qualifying criteria for certain hospitals excluded from the acute care hospital inpatient prospective payment system (sections 4411 to 4419). Provisions of these amendments that related to the current payment system were explained in detail and implemented in the acute care hospital inpatient prospective payment system final rule published in the **Federal Register** on August 29, 1997 (62 FR 45966).

Section 4411 of the BBA amended section 1886(b)(3)(B) of the Act and restricted the rate-of-increase percentages that are applied to each provider's target amount so that excluded hospitals and units experiencing lower inpatient operating costs relative to their target amounts receive lower rates of increase.

Section 4412 of the BBA amended section 1886(g) of the Act to establish a 15-percent reduction in capital payments for excluded psychiatric and rehabilitation hospitals and units and LTCHs, for portions of cost reporting periods occurring during the period of October 1, 1997, through September 30, 2002.

Section 4413(b) of the BBA amended section 1886(b)(3) of the Act to permit certain LTCHs to elect a rebasing of the target amount for the 12-month cost reporting period beginning during FY 1996.

Section 4414 of the BBA amended section 1886(b)(3) of the Act to establish caps on the target amounts for excluded hospitals and units at the 75th percentile of target amounts for similar facilities for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. These caps on the target amounts apply only to psychiatric and rehabilitation hospitals and units and LTCHs. Payments for these excluded hospitals and units are based on the lesser of a provider's cost per discharge or its hospital-specific cost per discharge, subject to this cap.

Section 4415 of the BBA amended section 1886(b)(1) of the Act by revising the percentage factors used to determine the amount of bonus and relief payments, and establishing continuous improvement bonus payments for cost reporting periods beginning on or after October 1, 1997 for hospitals and units excluded from the acute care hospital inpatient prospective payment system that meet specified criteria. If a hospital is eligible for the continuous improvement bonus, the continuous improvement bonus payment is equal to the lesser of: (1) 50 percent of the amount by which operating costs are less than expected costs; or (2) 1 percent of the target amount.

Sections 4416 and 4419 of the BBA amended section 1886(b) of the Act to establish a new framework for payments for new excluded providers. Section 4416 added a new section 1886(b)(7) to the Act that established a new statutory methodology for new psychiatric and rehabilitation hospitals and units and LTCHs. Before this change, new hospitals excluded from the acute care hospital inpatient prospective payment system were exempted from the target amount per discharge ceiling until the end of the first cost reporting period ending at least 2 years after they accepted their first patient. This new provider ''exemption'' was eliminated from all classes of excluded providers except children's hospitals for cost reporting periods beginning on or after October 1, 1997, by section 4419(a) of the BBA. Under section 4416, payment to these new excluded providers for their first two cost reporting periods is limited to the lesser of the operating costs per case, or 110 percent of the national median of target amounts, as adjusted for differences in wage levels, for the same class of hospital for cost reporting periods ending during FY 1996, updated to the applicable period.

It is important to note that before enactment of the BBA, the payment provisions for excluded hospitals and units applied consistently to all classes of excluded providers (that is, psychiatric, rehabilitation, long-term care, children's, and cancer). However, effective for cost reporting periods beginning on or after October 1, 1997, there are specific payment provisions for certain classes of excluded providers, as well as modifications for all excluded providers.

Section 4417 of the BBA specified that a hospital that was classified by the Secretary on or before September 30, 1995, as an excluded LTCH must continue to be so classified, notwithstanding that it is located in the same building, or on the same campus, as another hospital.

Section 4418 of the BBA amended section 1886(d)(1)(B)(v) of the Act, providing an additional category of hospitals that could qualify as cancer hospitals for purposes of exclusion from the acute care hospital inpatient prospective payment system.

2. BBRA

With the enactment of the BBRA of 1999, the Congress refined some of the policies mandated by the BBA for hospitals excluded from the acute care hospital inpatient prospective payment system. The provisions of the BBRA, which amended section 1886(b)(3)(H) of the Act relating to the current payment system for excluded hospitals, were explained in detail and implemented in the acute care hospital inpatient prospective payment system interim final rule published in the **Federal Register** on August 1, 2000 (65 FR 47026) and in the acute care hospital inpatient prospective payment system final rule also published on August 1, 2000 (65 FR 47054).

Section 4414 of the BBA provided for caps on target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997. Section 121 of the BBRA amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to these caps on the target amounts for existing psychiatric and rehabilitation hospitals and units and LTCHs, effective for cost reporting periods beginning on or after October 1, 1999 through September 30, 2002.

Section 122 of the BBRA provided for an increase in the continuous improvement bonus for eligible LTCHs and psychiatric hospitals and units for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2002.

3. BIPA

Two provisions of the BIPA that amended section 1886(b)(3) of the Act were directed at LTCHs. Section 307(a) of the BIPA provided for a 2-percent increase to the wage-adjusted 75th percentile cap on the target amount for existing LTCHs, effective for cost reporting periods beginning during FY 2001. Section 307(a) of the BIPA also provided a 25-percent increase to the hospital-specific target amounts for existing LTCHs for cost reporting periods beginning in FY 2001, subject to the wage-adjusted national cap.

B. Provisions for a LTCH Prospective Payment System

1. BBA

In section 4422 of the BBA, the Congress mandated that the Secretary develop a legislative proposal for a case-mix adjusted prospective payment system for LTCHs under the Medicare program, for submission by October 1999 based on consideration of several payment methodologies, including the feasibility of expanding the current

DRGs and the prospective payment system currently in place for acute care hospitals.

2. BBRA

Section 123 of the BBRA specifically requires that the prospective payment system for LTCHs be designed as a per discharge system with a DRG-based patient classification system that reflects the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 123 also requires that a report be submitted to the Congress describing the system design of the mandated LTCH prospective payment system no later than October 1, 2001, and that the system be implemented for cost reporting periods beginning on or after October 1, 2002.

3. BIPA

The BIPA reiterated the dates of implementation of the LTCH prospective payment system set forth in the BBRA. Section 307(b)(1) of the BIPA also directs the Secretary to examine the following specific payment adjustments: adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment. Furthermore, if the Secretary is unable to implement the prospective payment system by October 1, 2002, section 307(b)(2) of the BIPA mandates that a default LTCH prospective payment system be implemented, based on existing DRGs, modified where feasible to account for the specific resource use of long-term care patients.

V. Research and Data Supporting the Establishment of the LTCH Prospective Payment System

A. Legislative Requirements

Section 4422 of the BBA required us to formulate a legislative proposal on the development of a prospective payment system for LTCHs for submission to the Congress by October 1, 1999. To prepare for this proposal, we awarded a contract to The Urban Institute (Urban) following the enactment of the BBA for a multifaceted analysis of LTCHs, including a description of facilities and patients, as well as exploration of a variety of classification and payment system options.

In section 123(a) of the BBRA, the Congress mandated a per discharge, DRG-based model for the prospective payment system for LTCHs. Our basic objective remained unchanged—to arrive at a clearer understanding of the universe of LTCHs in relation to facility characteristics, beneficiary utilization, and beneficiary characteristics such as diagnoses, treatment, and discharge patterns.

Under the terms of our original contract with Urban, 3M Health Information Systems (3M) was subcontracted to provide an analysis and assessment of alternative classification systems for use in LTCHs in keeping with variables such as treatment patterns, patient demographics, and diagnoses and procedure codes for patients at LTCHs and acute care hospitals.

After the enactment of section 123 of the BBRA, we instructed 3M to limit its analyses to several DRG-driven classification systems, using the database constructed by Urban describing LTCHs, patients at LTCHs, and patients with the same diagnoses as LTCH patients treated in other facilities. We also contracted with 3M to develop and analyze the data necessary for us to design and develop the Medicare LTCH prospective payment system based on DRGs.

B. Description of Sources of Research Data

The records for all Medicare hospital inpatient discharges (including discharges for LTCHs) are contained in the Medicare provider analysis and review file (MedPAR), which includes patient demographics (age, gender, race, and residence zip code), clinical characteristics (diagnoses and procedures), and hospitalization characteristics. (Beneficiary data were encrypted to prevent the identification of specific Medicare beneficiaries.) The Medicare cost report data constitute the HCRIS, and includes information on facility characteristics, utilization data, and cost and charge data by cost center.

The 1997 Online Survey Certification and Reporting (OSCAR) system data provided information from the State survey and certification process to identify and characterize providers that participate in Medicare and Medicaid and include a list of all hospitals that were designated as LTCHs by Medicare. OSCAR data included the number of employees of various types and the number of different types of beds and care units, as well as variables on certification date, type of control, geographic region, and hospital size.

C. The Universe of LTCHs

1. Background Issues

LTCHs typically furnish extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. Generally, Medicare patients in LTCHs have been transferred from acute care hospitals and receive a range of ''postacute care'' services at LTCHs, including comprehensive rehabilitation, cancer treatment, head trauma treatment, and pain management. (MedPAC March 1999 Report to Congress, p. 95.) A LTCH must be certified as an acute care hospital that meets criteria set forth in section 1861(e) of the Act in order to participate as a hospital in the Medicare program. Generally, under Medicare, hospitals are paid as LTCHs if they have an inpatient average length of stay greater than 25 days.

LTCHs are a heterogeneous group of facilities ranging from old tuberculosis and chronic disease hospitals to newer facilities designed primarily to care for ventilator-dependent patients. They are unevenly distributed across the United States, with one-third (72 of 203 in 1997) located in Massachusetts, Texas, and Louisiana. As of 1997, 203 facilities were determined by Medicare to be LTCHs; by early 2000, 239 facilities were determined by Medicare to be LTCHs; and as of November 2001, OSCAR had data on 270 LTCHs.

LTCHs constitute a relatively small provider group in the Medicare program and have not been widely studied. Only limited information has been published about their characteristics in terms of types of patients served and resources used. As stated earlier in section V.A. of this preamble, the primary goal of the initial research contract with Urban was to increase our knowledge about LTCHs and their patients. In addition to describing the providers and patients, the study was expected to provide insight into the ways in which LTCHs differ from other Medicare postacute care providers. In the following summary and tables, we provide a description of Urban's findings that formed the basis for the design of the prospective payment system for LTCHs presented in the March 2002 proposed rule and in this final rule.

2. General Medicare Policies

Inpatient stays at LTCHs are covered under the Medicare Part A hospital benefit and include room and board, medical and nursing services, laboratory tests, X-ray, pharmaceuticals, supplies, and other diagnostic or therapeutic services (§§ 409.10 and 412.50). LTCHs can offer specialized services (for example, physical rehabilitation or ventilator-dependent care) or can provide more generalized services (for example, chronic disease care).

Hospital services are covered for up to 90 days during a Medicare-defined

''benefit period,'' which is a period that begins with admission of a Medicare beneficiary as an inpatient to an acute care or other hospital and ends when the beneficiary has spent 60 consecutive days outside of an inpatient facility (§ 409.60). There are 60 additional covered lifetime reserve days that may be used over a beneficiary's lifetime. One inpatient deductible payment ($792 in calendar year 2002) is required for each benefit period, so a beneficiary generally does not have to make a new deductible payment for a LTCH stay unless the LTCH stay is not preceded by another hospital stay. However, a beneficiary with a long LTCH stay is subject to a coinsurance payment ($198 in calendar year 2002) for days 61 through 90 of hospital use during a benefit period. For the lifetime reserve days, a Medicare beneficiary is subject to a daily coinsurance amount ($396 in calendar year 2002) (§ 409.61).

LTCHs must meet State licensure requirements for acute care hospitals and must have a provider agreement with Medicare in order to receive Medicare payment. Fiscal intermediaries verify that LTCHs meet the required average length of stay of greater than 25 days.

3. Exclusion From the Acute Care Hospital Inpatient Prospective Payment System

As discussed more fully in section III.B. of this preamble, LTCHs were excluded from the FY 1984 implementation of the acute care hospital inpatient prospective payment system and continued to be paid based on their cost per discharge, subject to per discharge limits.

4. Geographic Distribution

Overall, 203 LTCHs filed Medicare claims in 1997. This was the data set used by Urban for its analysis of the universe of LTCHs that formed the basis for policies we proposed in our proposed rule on March 22, 2002 (67 FR 13416). This number translates into an average of approximately one facility per 200,000 Medicare enrollees. As can be seen in Chart 1, LTCHs were not (and are still not) distributed across all States in proportion to the number of Medicare enrollees in those States. They were unevenly distributed across the United States, with one-third (72 of 203) located in Massachusetts, Texas, and Louisiana. These three States together accounted for 36 percent of the LTCHs, but only fewer than 10 percent of Medicare enrollees. Furthermore, 13 small States have no LTCHs, although they accounted for approximately 7 percent of Medicare enrollees. In contrast, the three largest Medicare States (California, Florida, and New York) accounted for 24.1 percent of Medicare enrollees together, but only 13.8 percent of LTCHs.

CHART 1.—PERCENTAGE DISTRIBUTION OF NUMBER OF LONG-TERM CARE HOSPITALS (LTCHS), MEDICARE ENROLLEES, AND CERTIFIED BEDS, BY STATE, 1997

State	Number of LTCHs	Percent of LTCHs	Number of medicare enrollees	Percent of medicare enrollees	Number of certified beds	Percent of certified beds
Alabama	1	0.5	696,586	1.8	191	1.0
Alaska	0	0.0	38,570	0.1	0	0.0
Arizona	4	2.0	667,226	1.7	187	1.0
Arkansas	0	0.0	453,195	1.1	0	0.0
California	12	5.9	3,920,674	9.9	1,304	7.1
Colorado	4	2.0	464,299	1.2	277	1.5
Connecticut	4	2.0	531,805	1.3	716	3.9
Delaware	0	0.0	111,171	0.3	0	0.0
District of Columbia	1	0.5	80,028	0.2	23	0.1
Florida	11	5.4	2,853,420	7.2	805	4.4
Georgia	6	3.0	915,577	2.3	557	3.0
Hawaii	1	0.5	163,217	0.4	13	0.1
Idaho	0	0.0	163,303	0.4	0	0.0
Illinois	5	2.5	1,701,123	4.3	703	3.8
Indiana	11	5.4	877,656	2.2	434	2.4
Iowa	0	0.0	498,288	1.3	0	0.0
Kansas	3	1.5	406,752	1.0	74	0.4
Kentucky	1	0.5	633,802	1.6	337	1.8
Louisiana	19	9.4	622,805	1.6	1,288	7.0
Maine	0	0.0	218,265	0.6	0	0.0
Maryland	4	2.0	651,710	1.7	465	2.5
Massachusetts	17	8.4	991,641	2.5	3,077	16.8
Michigan	3	1.5	1,435,420	3.6	280	1.5
Minnesota	2	1.0	669,708	1.7	313	1.7
Mississippi	2	1.0	428,729	1.1	65	0.4
Missouri	3	1.5	888,959	2.3	317	1.7
Montana	0	0.0	139,392	0.4	0	0.0
Nebraska	1	0.5	263,287	0.7	25	0.1
Nevada	3	1.5	225,152	0.6	106	0.6
New Hampshire	0	0.0	170,031	0.4	0	0.0
New Jersey	3	1.5	1,239,890	3.1	212	1.2
New Mexico	2	1.0	231,517	0.6	86	0.5
New York	5	2.5	2,780,994	7.0	1,262	6.9
North Carolina	1	0.5	1,129,329	2.9	59	0.3
North Dakota	0	0.0	107,628	0.3	0	0.0
Ohio	7	3.4	1,766,266	4.5	653	3.6
Oklahoma	8	3.9	523,358	1.3	294	1.6
Oregon	0	0.0	500,035	1.3	0	0.0
Pennsylvania	6	3.0	2,183,850	5.5	412	2.3
Rhode Island	1	0.5	177,247	0.4	700	3.8
South Carolina	2	1.0	562,732	1.4	0	0.0
South Dakota	0	0.0	123,401	0.3	211	1.2
Tennessee	6	3.0	838,357	2.1	210	1.1
Texas	36	17.7	2,275,673	5.8	1,818	9.9
Utah	1	0.5	204,525	0.5	39	0.2
Vermont	0	0.0	89,821	0.2	0	0.0
Virginia	3	1.5	893,602	2.3	664	3.6
Washington	2	1.0	742,589	1.9	97	0.5
West Virginia	0	0.0	349,684	0.9	0	0.0
Wisconsin	1	0.5	806,951	2.0	34	0.2
Wyoming	1	0.5	65,699	0.2	3	0.0
Total	195	100.00	36,322,068	100.00	18,311	100.00

Source: 1997 Online Survey Certification and Reporting System (OSCAR).

Although the distribution of certified beds generally tracked the distribution of LTCHs across States, there is not always a direct relationship between the number of LTCHs and the bed capacity in a given State. For instance, Massachusetts had only 8.4 percent of LTCHs, but 16.8 percent of Medicare-certified beds. In contrast, Texas had 17.7 percent of LTCHs, but only 9.9 percent of the certified beds.

5. Characteristics by Date of Medicare Participation

The OSCAR system provided data captured by the State survey and certification process that can be used to identify and characterize providers participating in Medicare and Medicaid. The following analyses were based on LTCHs for which data were available. Eight facilities, which accounted for only 1 percent of all LTCH stays and 1.3 percent of certified beds, were excluded from the analysis since 1997 OSCAR records were not available for these facilities.

Given the known payment variations for old and new facilities that were excluded facilities paid under the target amount methodology, we divided the LTCHs by age (the date of the LTCH's first Medicare participation, as reported by OSCAR) to gain a sense of the variation among the existing LTCHs in 1997. A strong correlation was found between the age of a LTCH and other key characteristics, such as location and ownership control, as well as operating costs and Medicare payments. For analytical purposes, therefore, the total sample of LTCHs was stratified based on age (''old,'' ''middle,'' or ''new''). Of the 195 LTCHs in OSCAR in 1997, 20 percent were in existence before the acute care hospital inpatient prospective payment system and the acute care hospital inpatient prospective payment system exclusions went into effect in October 1983 (old LTCHs); 30 percent were determined to be LTCHs between October 1983 and September 1993 (middle LTCHs); and 50 percent were determined to be LTCHs between October 1993 and September 1997 (new LTCHs). This pattern is consistent with reports of the large growth in the number of LTCHs in recent years. (As of November 2001, OSCAR had data on 270 LTCHs, which indicate that the growth has continued.)

Old LTCHs were generally located in the northeast region of the United States, while newer LTCHs are typically located in the southern region. Most notably, the ownership of the LTCHs that began Medicare participation before and after the implementation of the acute care hospital inpatient prospective payment system was quite different. Old LTCHs were either government controlled (about 63 percent) or nonprofit (about 37 percent). In contrast, one-half of the LTCHs that began participation in Medicare between 1983 and 1993 and two-thirds of those that began participation in Medicare in FY 1994 or later were proprietary facilities. Virtually no new LTCHs were government controlled.

6. Hospitals-Within-Hospitals and Satellite Facilities

The Medicare statute does not contemplate the recognition of ''LTCH units'' of prospective payment system acute care hospitals; the statute does reference rehabilitation and psychiatric units. Long-term care units of prospective payment system hospitals are not allowed in part because of the concern that transfers of acute care patients into the LTCH units could inappropriately maximize prospective payments under the acute care hospital inpatient prospective payment system. The presence of a long-term care ''unit'', excluded from the acute care hospital inpatient prospective payment system and co-located in an acute care hospital, could enable the acute care hospital to shift patients to the long-term care ''unit'' without completing the full course of treatment. These patient transfers could result in inappropriate payments under Medicare since the acute care hospital would make money in those cases where it received a full DRG payment without providing the full course of treatment to the beneficiary and could avoid losing any money for other more costly patients by prematurely discharging them to the LTCH. Since payments to hospitals under the acute care hospital inpatient prospective payment system were based on hospital costs that included the costs of patients with longer lengths of stay, such a patient shift would result in an ''overpayment'' to the acute care hospital and the LTCH would receive an additional payment for that same patient.

Nonetheless, in the mid-1990s, of the roughly 150 LTCHs in existence at the time, about 12 recently established LTCHs were, in fact, LTCHs located in the buildings or on the campuses of acute care hospitals. In order to prevent the shifting of costs within the Medicare payment system that would result from inappropriate transfers between the inpatient acute care hospital and the LTCH located within the acute care hospital, we have implemented additional qualifying criteria at § 412.22(e) for these entities. These criteria require that in order to be excluded from the acute care hospital inpatient prospective payment system, a hospital located in or on the campus of an acute care hospital (referred to as a ''hospital-within-a-hospital'') must have a separate governing body, chief executive officer, chief medical officer, and medical staff. In addition, the hospital must perform basic functions independently from the host hospital, incur no more than 15 percent of its total inpatient operating costs for items and services supplied by the hospital in which it is located, and have an inpatient load of which at least 75 percent of patients are admitted from sources other than the host hospital. Originally, these regulations were effective as of October 1994. However, section 4417(a) of the BBA amended section 1886(d)(1)(B) of the Act to provide that a hospital that was excluded from the acute care hospital inpatient prospective payment system on or before September 30, 1995, as an LTCH, must continue to be so classified, notwithstanding that it is located in the same building or in one or more buildings located on the same campus as another hospital (§ 412.22(f)). This provision, codified in § 412.22(f), exempts certain LTCHs that are hospitals-within-hospitals from the ownership and control requirements discussed above.

In the late 1990s, we became aware of a newly developing entity that was physically similar, but legally unrelated, to a hospital-within-a-hospital. These entities were hospital-within-hospital type facilities (in the buildings or on the campuses of acute care hospitals) owned by a separate existing LTCH. We identified these facilities as ''long-term care hospital satellites.''

In the July 30, 1999 **Federal Register** (64 FR 41540), we revised § 412.22(h) to require that in order to be excluded from the acute care hospital inpatient prospective payment system, a satellite of a hospital: (1) Must maintain admission and discharge records that are separately identified from those of the hospital in which it is located; (2) cannot commingle beds with beds of the hospital in which it is located; (3) must be serviced by the same fiscal intermediary as the hospital of which it is a part; (4) must be treated as a separate cost center of the hospital of which it is a part; (5) for cost reporting purposes, must use an accounting system that properly allocates costs and maintains adequate data to support the basis of allocation; and (6) must report costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as that hospital. In

addition, the satellite facility must independently comply with the qualifying criteria for exclusion from the acute care hospital inpatient prospective payment system. The total number of State-licensed and Medicare-certified beds (including those of the satellite facility) for a hospital that was excluded from the acute care hospital inpatient prospective payment system for the most recent cost reporting period beginning before October 1, 1997, may not exceed the hospital's number of beds on the last day of that cost reporting period.

7. Specialty Groups of LTCHs by Patient Mix

There is a widely held view that the population of LTCHs is heterogeneous. We believe that understanding the composition of this population and identifying and classifying subgroups within it are fundamental to designing a prospective payment system for LTCHs.

Broad categories of conditions as defined by major diagnostic categories (MDCs), the principal diagnostic categorization tool used under the acute care hospital inpatient prospective payment system, were used to classify LTCHs according to the medical conditions of their patient caseloads. (MDCs were formed by dividing all possible principal diagnoses into 25 mutually exclusive categories. Most MDCs correspond to a major organ system, though a few correspond to etiology.)

We also explored the possibility of grouping patients by DRGs or by selected individual diagnoses. These attempts resulted in creating groups too small for any effective characterization. However, the analysis did reveal that while some LTCHs treat a wide range of conditions, others specialize in one or two types of conditions. In order to analyze a grouping based on patient mix, under its contract with us, Urban first examined the proportion of facilities' caseloads in specific MDCs. There were five MDCs in which at least one LTCH has a majority (that is, more than 50 percent) of its cases. Patients with respiratory system problems were the most common caseload concentration—in 1997, 13 percent of LTCHs had a caseload concentration of 50 percent to 75 percent, and another 7 percent of LTCHs had more than 75 percent of their cases in this MDC.

The other three MDCs that made up a majority of at least one LTCH's patient caseload (nervous system MDC, musculoskeletal and connective tissue disorders MDC, and factors influencing health status MDC) were all related to rehabilitation needs. (Because rehabilitation-related DRGs were common to LTCHs and fell into the ''Factors Influencing Status'' MDC, we are classifying all cases in this MDC as rehabilitation services for the purpose of this analysis.) Seven percent of LTCHs had a majority of their caseload in an MDC related to rehabilitation-related services. A significantly less common concentration was seen in the 2 percent of LTCHs that had a majority of their patients in the mental diseases and disorders MDC. All but two LTCHs in our analysis had some share of patients with respiratory system problems. Similarly, all but five LTCHs had some patients with circulatory problems.

Based on these findings, we developed a grouping that consists of four broad categories of LTCHs based on patient caseload. Facilities with greater than 50 percent of their cases in the respiratory MDC were assigned to a ''respiratory specialty'' group for the purpose of this analysis. Similarly, all facilities with over 50 percent of their caseload in the mental MDC were designated as ''mental specialty'' facilities. The three rehabilitation-related MDCs were combined into one ''rehabilitation-related MDC'' category and grouped into a ''rehabilitation specialty'' group. All remaining facilities (that did not have high concentrations of patients in the respiratory MDC, the mental MDC, or the rehabilitation-related MDCs category) were placed into a ''multispecialty'' facility group. LTCHs in this category provide care to a wider range of patient types than LTCHs in the first three categories.

To better understand the relatively large number of multispecialty LTCHs, we explored their MDC composition. Not unexpectedly, most of these facilities had high proportions of cases in the respiratory MDC and the rehabilitation-related MDCs category, although some LTCHs did not serve either of these populations in great numbers. Few LTCHs did have a significant share of their caseload in either the respiratory MDC or the rehabilitation-related MDCs category. Only 2 percent of multispecialty LTCHs had less than 25 percent of their caseload in either specialty group. Similarly, only 7 percent of multispecialty facilities had less than 35 percent of their caseload in either of the two groups. In contrast, about 60 percent of LTCHs had at least half of their caseload in either the respiratory MDC or the rehabilitation-related MDCs category. This high share demonstrated that, despite their assignment to the multispecialty category, most LTCHs served a high percentage of patients with respiratory or rehabilitation problems, or both.

Although respiratory and rehabilitation specialty facilities were prevalent in the LTCH population, there were also some ''niche'' LTCHs that have unique patient populations or provide uncommon services. These hospitals included, for example, a large hospital where most admitted individuals (90 percent) die in the facility.

Several LTCHs provided services for special populations. One facility provided services for a prison population. A large share of this facility's funding was through Medicaid; cost report data showed that Medicaid covers two-thirds of its patient stays.

Some other facilities worked with similarly specialized populations and have very small Medicare caseloads. In particular, two facilities that focused on developmentally disabled children and younger adults had fewer than 10 Medicare stays in 1997. Cost reports show that one of these facilities, which provides rehabilitation for its Medicare patients, has few discharges (under 100) regardless of payer source. The other, which provides mostly psychiatric services, relies on public funding for only a small share of its discharge payments.

Although there are a few niche facilities in the LTCH population, our analysis indicated that a preponderance of the LTCHs could be classified in distinct specialty groups that focused on adult rehabilitation and respiratory system care.

8. Sources and Destinations of LTCH Patients

Another useful perspective on LTCHs was the pattern of sources from which patients are admitted to LTCHs and destinations to which LTCH patients are discharged. This information showed how such transition patterns differ among the specialty groups. In general, the findings were consistent with the notion that LTCHs as a group were heterogeneous in terms of the patients they serve.

The vast majority (70 percent) of LTCH patients were admitted from acute care hospitals. Within this group, acute care patients whose stays were designated as ''outlier'' stays, as defined by section 1886(d)(5)(A)(i) of the Act and implemented in § 412.80, were identified separately. Sixteen percent of LTCH admissions were acute care hospital outlier patients, while 54 percent were admitted from acute care hospitals but did not have extraordinarily long acute care stays.

After acute care hospitals, direct admission from the community was the next most common source of admissions (14 percent) to LTCHs.

The admission patterns varied somewhat by LTCH specialty type. Notably, 85 percent of admissions to respiratory specialty LTCHs were from acute care hospitals, including 22 percent that were acute care hospital outlier cases. A very small percentage (7 percent) of admissions to respiratory specialty LTCHs were from the community. In contrast, the admission sources for the rehabilitation specialty LTCHs were more similar to that of the multispecialty LTCHs. Notably, a higher than average share of patients come from SNFs (8 percent) and HHAs (6 percent) and a lower percentage of patients transitioned from acute care hospital outlier stays (12 percent). A relatively large share (11 percent) of patients at rehabilitation specialty LTCHs were admitted directly from the community compared to patients at respiratory specialty LTCHs (7 percent). These findings suggest that patients admitted to rehabilitation specialty LTCHs might present a less medically intensive clinical picture than patients admitted to respiratory specialty LTCHs.

The admission pattern of patients admitted to the mental specialty LTCHs was quite different from those of the other specialties. Thirty one percent of patients are admitted from acute care hospitals, and only 2 percent of patients are admitted after being acute care hospital outlier cases. In contrast, 40 percent of patients were admitted directly from the community and 27 percent were admitted from some other type of Medicare provider.

An analysis of the pattern of discharge destinations for LTCHs shows that, overall, 38 percent of LTCH stays were discharged to the community without additional Medicare services. Almost equal percentages (18 percent) were discharged to SNFs and acute care hospitals, and 21 percent of patients were discharged to HHAs.

Some variations in discharge destination patterns existed among LTCHs by specialty. Relative to the overall sample, the respiratory specialty LTCHs had higher than average percentages of patients discharged to SNFs (24 percent versus 18 percent), and lower percentages discharged to HHAs (14 percent versus 21 percent). However, rehabilitation specialty facilities had a relatively high proportion of cases (34 percent) discharged to HHAs, and a lower than average proportion discharged to the community without additional Medicare services (28 percent versus 38 percent). Finally, mental specialty hospitals have an unusually high percent of cases (71 percent) discharged to the community without additional Medicare services. These findings suggest that patients served by respiratory specialty LTCHs are more likely to require extended care in institutional settings (for example, SNFs), while patients discharged from rehabilitation specialty facilities also require extended care, but not necessarily in institutional settings.

9. LTCHs and Patterns Among Postacute Care Facilities

Urban's research also produced data regarding a comparison of LTCHs with other postacute care settings in order to provide us with the broadest possible understanding of the universe of LTCHs. The findings were only preliminary comparisons of patients among and across postacute settings because of the nature of each category of postacute care providers. Even though data suggest substantial clinical differences among the providers with some areas of overlap, because of some similarities we found it useful to draw parallels and distinctions among postacute care providers. Moreover, findings from this research supported conclusions published in several reports to the Congress produced by ProPAC and MedPAC over the past decade.

Most patients in LTCHs had several diagnosis codes on their Medicare claims, indicating that they had multiple comorbidities and are probably less stable upon admission than patients admitted to other postacute care settings. Relative to IRFs, LTCHs had a higher proportion of patient costs attributable to ancillary services (for example, pharmacy, laboratory, and radiology charges) (MedPAC March 1999 Report to Congress, p. 95). LTCHs also provided care to a disproportionately large number of Medicare beneficiaries who are eligible because of disability. While individuals with disabilities make up about 10 percent of the Medicare population, they make up 17 percent of LTCH patients.

Urban's analysis also explored the demographic characteristics of LTCH patients compared to IRF patients. The proportion of LTCH patients who are under 65 years of age (18 percent) was twice that of IRF patients (9 percent). The share of LTCH patients over 85 years old was slightly higher (18 percent) compared to IRF patients (14 percent). LTCHs also had a higher proportion of male patients and a lower proportion of white patients than IRFs. LTCHs had long median lengths of stay: 21 days versus 16 days for IRFs. About one-third of the LTCH Medicare stays were by beneficiaries who are also eligible for Medicaid, compared to fewer Medicaid-eligible beneficiary stays at IRFs (17 percent). It has been widely documented that dually eligible beneficiaries are generally much sicker than non-Medicaid eligible Medicare beneficiaries.

Urban's analysis also included a description of the demographic characteristics of LTCH patient stays by admission sources—outlier acute care hospital, nonoutlier acute care hospital, and other. Those with prior outlier acute care hospital stays seem to be the most distinctive group in terms of length of stay, gender, race, and poverty: they had the highest mean and median length of stay in the LTCH, the highest male proportion, the highest white proportion, and the lowest proportion of Medicaid-eligible patients. However, in terms of age, those with prior hospital stays (whether outlier or nonoutlier) were quite different from those with other admission sources. Those without a prior acute care hospital stay were younger and about twice as many are under age 65, whose mean age was about 5 and 3 years lower than those with a prior outlier stay and those with a prior nonoutlier stay, respectively. Among those with an acute care hospital stay, the nonoutlier patients were slightly older on average, with higher percentages in the oldest groups (75 to 84 and 85 plus) and the highest median age of all three groups.

The policies in the March 22, 2002 proposed rule and in this final rule were determined in part based on analysis of the above data and information gathered on LTCHs and their Medicare patients.

D. Overview of Systems Analysis for the LTCH Prospective Payment System

For the systems analysis, 3M used the MedPAR (FY 1999 through FY 2000), OSCAR (FY 2000), and HCRIS (FYs 1998 and early 1999) files for the March 22, 2002 proposed rule. Specifically, 3M performed the following tasks:

- Construction of an updated data file, using the most recent data available from CMS.
- Analysis of issues, factors, or variables and presentation of options for possible use in the design and implementation of the prospective payment system.
- Data simulation of various system features to analyze their impact on the design of the prospective payment system.

A data file was constructed to serve as the basis of our patient classification system presented in the proposed rule

and the development of proposed payment weight rates and proposed payment adjustments. The analysis of this data file helped us regarding the structure of the prospective payment system in the proposed rule. We relied upon patient charge data from FY 2000 MedPAR for proposing LTC–DRG weights and upon costs data from FY 1998 and FY 1999 cost reports for proposed payment rates.

For this final rule, we used updated and expanded data from the FY 2000 MedPAR file to develop the payment weight rates and payment adjustments for FY 2003. Section X.K. of this final rule contains a detailed discussion of the data used to develop the FY 2003 payment rates and payment adjustments, the public comments received on the proposed rates and adjustments, and our responses to those comments.

E. Evaluation of DRG-Based Patient Classification Systems

Section 307(b)(1) of Public Law 106–554 modified the requirements of section 123 of Public Law 106–113 by specifically requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH prospective payment system] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data.''

In order to comply with statutory mandates, our evaluation of DRG-based patient classification systems focused on two models—the LTC-all patient-refined DRGs (LTC–APR–DRGs, Version 1.0), a severity-based case-mix classification system developed specifically for LTCHs; and the LTC–CMS–DRGs, a modification of the DRG system used in the acute care hospital inpatient prospective payment system.

The LTC–APR–DRGs, a condensed version of 3M's all-patient refined DRGs (APR–DRGs) for acute care hospitals, was developed by 3M Health Information Systems, for exclusive use in LTCHs. The LTC–APR–DRG system was designed to reflect the clinical characteristics of LTCH patients. This case-mix classification model contains 26 base LTC–APR–DRGs, subdivided by 4 severity of illness levels to yield 104 classification levels. In this system, the patient's secondary diagnoses, their interaction, and their clinical impact on the primary diagnosis determine the severity level assigned to each of the 26 LTC–APR–DRGs.

The LTC–CMS–DRGs are based on research done by The Lewin Group (Developing a Long-Term Hospital Prospective Payment System Using Currently Available Administrative Data for the National Association of Long-Term Hospitals (NALTH), July 1999). This model uses our existing hospital inpatient DRGs with weights that accounted for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs. In order to deal with the large number of low volume DRGs (all DRGs with fewer than 25 cases), the LTC–CMS–DRG model groups low volume DRGs into 5 quintiles based on average charge per discharge. The result was 184 classification groups (179 DRG-based and 5 charge-based payment groups) based on patient data from FYs 1994 and 1995. (CMS updated this analysis using patient data from FYs 1999 and 2000 for purposes of system evaluations.)

As discussed in the March 22, 2002 proposed rule (67 FR 13426), under either classification system, DRG weights would be based on data for the population of LTCH discharges, reflecting the fact that LTCH patients represent a different patient mix than patients in short-term acute care hospitals. GROUPER software programs enabled us to examine the most recent LTCH and acute care hospital inpatient prospective payment system patient discharge data in light of the features of each system. Using regression analyses and simulations, the impact of each patient classification system on potential adjustment features for the prospective payment system was assessed. (Data files used in these analyses are specified in section V.B. of this preamble.) Our medical staff as well as physicians involved in treatment of patients at LTCHs provided additional input from the standpoint of clinical coherence and practical applicability.

The system that we are adopting in this final rule for the LTCH prospective payment system is the LTC–CMS–DRG GROUPER based on the Lewin model that we proposed in the March 22, 2002 proposed rule (67 FR 13426). We believe this system accurately predicts costs without the problems that we believe could be inherent with the APR–DRG system. (In section IX. of this final rule, which describes the functioning of the classification system as a component of the LTCH prospective payment system, the LTC–CMS–DRGs are referred to as the LTC–DRGs.)

It is important to note that we have analyzed both systems based on MedPAR files generated by LTCH patient data, using the best available data. Since the TEFRA payment system, under which LTCHs are currently paid, is not tied to patient diagnoses, the coding data from LTCHs have not been used for payment. Nevertheless, data analyses indicated that there was a minimal difference in both systems' abilities to predict costs. (The difference in the R^2, a statistical measure of how much variation in resource use among cases is explained by the models, was only 0.0313.)

In the March 22, 2002 proposed rule (67 FR 13426), we indicated that we believed that either classification system would result in more equitable payments for LTCHs compared to current payment methods. The LTCH prospective payment system would generally improve the accuracy of payments for more clinically complex patients. (See our discussion of the TEFRA payment system in section III.C. of this final rule.) As the Congress intended, the DRG weights under the LTCH prospective payment system would reflect the ''* * * different resource use of long-term care hospital patients.'' Patients requiring more intensive complex services would be classified in LTC–DRGs with higher relative weights and hospitals would receive appropriately higher payments for these patients. In the proposed rule, we solicited comments on the impact that one system may have over another as it applies to different kinds of LTCHs. Any public comments that we received on the impact of both systems are included in sections IX. and XII. of this final rule.

Although either system would result in more equitable payments to LTCHs, we have several interrelated concerns about adopting the LTC–APR–DRG system based upon its complexity, its clinical subjectivity, and its utility as it relates to other Medicare prospective payment systems. The LTC–APR–DRG model provides a clinical description of the population of LTCHs, patients exhibiting a range of severity of illness with multiple comorbidities as indicated by secondary diagnoses. The clinical interaction of the primary diagnosis with these comorbidities determines the severity level of the primary diagnoses, resulting in the final assignment to a LTC–APR–DRG by the GROUPER software designed for this system.

One aspect of our examination of the LTC–APR–DRG system included clinical review of actual case studies provided by physicians at several LTCHs and evaluations of the LTC–APR–DRG assignments that would have resulted based on the clinical logic of

the APR–DRG GROUPER. A review of a number of those cases by different medical professionals resulted in different possible classifications for the GROUPER program. Looking at the same case, different views were held as to which APR–DRG category or to which level of severity the case should be grouped. Given the array of specialization at different LTCHs reflecting a range of services and patient types, as described in section V.C.7. of this preamble, we believe that we lack sufficient data, at this point in time, to definitely determine the effect of particular comorbidities on patient resource needs in LTCHs. Furthermore, it appears that depending on how many of the diagnoses are coded, medical judgement suggests that it could be possible to classify the same patient in more than one group or level of severity. Because of these concerns, we believe that payments under such a policy could be insufficiently well-defined, given currently available data, to ensure consistently appropriate Medicare payments.

We note that the prospective payment system that we have adopted for IRFs is based on a patient classification system that includes a measure of comorbidities, the combination of the case-mix group (CMG) and comorbidity tier. In general, most IRF patients are treated for one primary rehabilitation condition (for example, a hip replacement) that is associated with functional measures and sometimes age. The CMGs constructed for IRF patients account for diagnostic, functional, and age variables. These variables are used to explain the variability in the cost among the various CMGs. Some of the remaining variability in cost could then be further explained by selected comorbidities which the inpatient rehabilitation data showed were statistically significant.

In contrast, determining whether particular comorbidities increase the cost of a case for a LTCH patient is complicated by the nature of the clinical characteristics of these patients. More specifically, many LTCH patients have numerous conditions that may not all be relevant to the cost of care for a particular discharge. Although the patient actually has a specific condition, including this condition among secondary diagnoses coded under the LTC–APR–DRG system may assign an inaccurate severity level to the primary diagnosis and result in inappropriate LTC–APR–DRG payment. We also believe that reliance on existing comorbidity information submitted on LTCH bills could result in significant variation in the assignment of the specific LTC–APR–DRGs.

The LTC–CMS–DRG system is a system that is familiar to hospitals because it is based on the current DRG system under the acute care hospital inpatient prospective payment system. We believe that the familiarity of the LTC–CMS–DRG model may best facilitate the transition from the reasonable cost-based system to the prospective payment system as well as providing continuity in payment methodology across related sites of care (for example, an acute care hospitalization for a patient with a chronic condition).

We further note that the adoption of severity-adjusted DRGs will be explored by CMS for use under the acute care hospital inpatient prospective payment system. In its June 2000 Report to Congress, MedPAC recommended that the Secretary ''* * * improve the hospital inpatient prospective payment system by adopting, as soon as practicable, diagnosis related group refinements that more fully capture differences in severity of illness among patients.'' (Recommendation 3A, p. 63)

In the March 22, 2002 proposed rule, although we did not propose adopting the LTC–APR–DRGs in the LTCH prospective payment system, we did solicit comments on its possible use.

Even though we are using LTC–DRGs in the LTCH prospective payment system in this final rule, we may have the opportunity to propose a severity-adjusted patient classification for LTCHs in the future, particularly if the acute care hospital inpatient prospective payment system moves in this direction. Any public comments that we received on the possible use of LTC–APR–DRG or some other system in the future are addressed in section IX. of this final rule.

VI. Recommendations by MedPAC for a LTCH Prospective Payment System

As we noted in the section III.E. of this final rule, since the establishment of the acute care hospital inpatient prospective payment system in 1983, the topic of postacute care payments under Medicare has been addressed in reports to the Congress prepared by ProPAC and its successor, MedPAC. Recommendations in these reports encouraged modifications to Medicare payment policies, examined the differences among postacute care providers and within each category of providers, and reiterated the goal of eventually implementing prospective payment systems for providers being paid under the target amount payment methodology.

In its March 1, 1996 Report and Recommendations to the Congress, ProPAC recommended that ''prospective payment systems should be implemented for all postacute services. The payment method for each service should be consistent across delivery sites. The Secretary should explore methods to control the volume of postacute service use, such as bundling services for a single payment.'' (Recommendation 20, p. 75)

The following year, in its March 1, 1997 Report and Recommendations to the Congress, ProPAC recommended ''* * * the Congress and the Secretary to consider the overlap in services and beneficiaries across postacute care providers as they modify Medicare payment policies. Changes to one provider's payment method could shift utilization to other sites and thus fail to curb overall spending. To this end, ProPAC commends HCFA's [now CMS'] efforts to identify elements common to the various facility-specific patient classification systems to use in comparing beneficiaries across settings.'' Ultimately, Medicare should move towards more uniform payment policies across sites, the Report continued, and ''payment amounts should vary depending on the intensity and nature of the services beneficiaries require, rather than on the setting. Further, providers should have incentives to coordinate services or an episode* * *.'' (p. 60)

However, with enactment of the BBA, the Congress enacted legislation to provide for distinct prospective payment systems for HHAs (section 4603(b)), SNFs (section 4432(a)), and IRFs (section 4421). The BBA further required the development of a legislative proposal for the case-mix adjusted LTCH prospective payment system. Section 123 of the BBRA requires the Secretary to develop a per discharge DRG-based system for LTCHs, and section 307(b)(1) of the BIPA mandates that the Secretary examine the feasibility and impact of basing payments to LTCHs using the existing or refined DRGs, modified to account for the resource use of LTCH patients. Thus, the Congress mandated distinct systems that would result in different payments, depending on the type of Medicare provider, and not a system that is uniform across sites of care.

Notwithstanding the mandate to establish postacute care prospective payment systems, MedPAC continued to articulate concern regarding the overlap of services among postacute providers. In its June 1998 Report to Congress, MedPAC stated that ''all of these policy changes, in combination with the fact

that similar services can be provided in multiple postacute settings, indicate the need for continued monitoring and analysis of postacute providers, policies, and service utilization.'' (p. 90)

In its March 1999 Report to Congress, MedPAC encouraged the Secretary to ''* * * collect a core set of patient assessment information across all postacute care settings.'' (Recommendation 5A, p. 82)

Section 123 of the BBRA specifically mandated a per discharge, DRG-based prospective payment system for LTCHs and established a timetable for the presentation of the proposed system in a report to the Congress by October 1, 2001 and for implementation of the actual prospective payment system by October 1, 2002. Further direction for a distinct prospective payment system for LTCHs was indicated in section 307(b) of the BIPA, which directed the Secretary to examine a number of payment adjustment factors and established a default system if the Secretary is unable to meet the implementation timetable.

As we developed the prospective payment system for LTCHs described in this final rule, however, we wish to state that we do not believe that the establishment of distinct prospective payment systems for each postacute care provider group eliminates the need to monitor payments and services across all service settings. We endorse MedPAC's Recommendation 3G, in its March 2000 Report to Congress, that encourages the Secretary to ''assess important aspects of the care uniquely provided in a particular setting, compare certain processes and outcomes of care provided in alternative settings, and evaluate the quality of care furnished in multiple-provider episodes of postacute care.'' (p. 65) We intend to monitor the appropriateness of LTCH stays by tracking the number of LTCH patients and SNF patients and the frequency of subsequent admissions to an acute care hospital. We believe these data will be valuable in assessing the outcome of care provided in these settings.

Furthermore, we strongly support the additional research that will be required to choose or to develop an assessment instrument that will evaluate the quality of services delivered to beneficiaries in postacute settings.

VII. Evaluated Options for the Prospective Payment System for LTCHs

Section 123 of the BBRA and section 307(b) of the BIPA establish the statutory authority for the development of the prospective payment system for LTCHs that is discussed in this final rule. Under the BBRA, we are required to:

- Develop a per discharge prospective payment system for inpatient hospital services furnished by LTCHs described in section 1886(d)(1)(B)(iv) of the Act.
- Include an adequate patient classification system that is based on DRGs that reflect the differences in patient resource use and costs.
- Maintain budget neutrality.
- Submit a report to the Congress describing this system by October 1, 2001.
- Implement this system for cost reporting periods beginning on or after October 1, 2002.

Section 307(b) of the BIPA modified the requirements of section 123 of the BBRA by requiring the Secretary to—

- Examine the feasibility and the impact of basing payment under the prospective payment system on the use of existing (or refined) 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 data.
- Examine appropriate adjustments to LTCH prospective payments, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

Although the statutory mandate for development of the LTCH prospective payment system established in the BBRA and the BIPA requires a per discharge, DRG-based system, generally the statute gives the Secretary broad discretion in designing the prospective payment system. The design of any prospective payment system requires decisions on the following issues:

- The categories used to classify services such as DRGs.
- The methodology for calculating the relative weights that are assigned to each patient category to reflect the relative difference in resource use across DRGs (these are relative values in economic terminology).
- The methodology for calculating the base rate, which is the basis for determining the DRG-based Federal payment rates. It is a standardized payment amount that is based on average costs from a base period and also reflects the combined aggregate effects of the payment weights and various facility-level and case-level adjustments. Operating and capital-related costs may be combined in this base rate or may be treated separately.
- Adjustments to the base rate to reflect cost differences across providers, such as disproportionate share adjustments, indirect graduate medical education programs, and outliers.
- Finally, a procedure for the transition from the current system to the DRG-based prospective payment system must be established.

We pursued a two-pronged strategy as we developed the prospective payment system for LTCHs. First, we analyzed the data and empirical facts about LTCH patients and providers summarized in section V.C. of this preamble. Secondly, in light of this information, we analyzed each option based on regressions and simulations, using the data sets described in section V.B. of this preamble.

Both technical and policy considerations were important in these design proposals. We reviewed features of other recent prospective payment systems designed or implemented by CMS for other postacute care providers to determine the feasibility of including features in the LTCH prospective payment system and to identify modifications that might enhance their application for this system. In addition, we considered factors that were important to the development of Medicare's acute care hospital inpatient prospective payment system, such as urban and rural location and whether the hospital served a disproportionate share of low-income patients. We also analyzed clinical significance, administrative simplicity, availability of data, and consistency with other Medicare payment policies.

In addition to satisfying statutory requirements, the design of the prospective payment system for LTCHs presented in this final rule is the result of the following factors:

- Our empirical understanding of the ''universe'' of LTCHs and long-term care patients, as set forth in section V.C. of this preamble.
- Our experience with the acute care hospital inpatient prospective payment system.
- Consideration of recommendations in MedPAC's reports to Congress on postacute care.
- Our monitoring of the establishment and continuing development and refinement of prospective payment systems for IRFs, SNFs, and HHAs.

In addition, as we deliberated on the choice of the specific model of DRG-based system that was to be used for the LTCH prospective payment system, we gathered information from LTCH physicians and LTCH representatives.

VIII. Elements of the LTCH Prospective Payment System

A. Overview of the System

We are implementing a prospective payment system for LTCHs that will use

information from LTCH patient records to classify patients into distinct LTC–DRGs based on clinical characteristics and expected resource needs. This patient classification system is discussed in detail in section IX. of this final rule. The separate payments that will be calculated for each LTC–DRG and any adjustments to these payments are discussed in detail in section X.J. of this final rule. Below we discuss the applicability of the requirements of the system and other implementation provisions.

B. Applicability

1. Criteria for Classification

Our existing regulations at 42 CFR Part 482, Subparts A through D, set forth the general conditions that hospitals must meet to qualify to participate in Medicare. There are no additional conditions for LTCHs as there are for psychiatric facilities.

Criteria for classification of a hospital as a LTCH for purposes of payment are set forth in existing § 412.23(e). Section 412.23(e) provides that a LTCH must—

- Have a provider agreement to participate as a hospital and an average inpatient length of stay greater than 25 days; or for cost reporting periods beginning on or after August 5, 1997, for a hospital that was first excluded from the acute care hospital inpatient prospective payment system in 1986, have an average inpatient length of stay of greater than 20 days and demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease, as defined in regulations. The calculation of the average inpatient length of stay is calculated by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period.
- Meet the additional criteria specified in § 412.22(e) if it is to be classified as a hospital-within-a-hospital and to be excluded from the acute care hospital inpatient prospective payment system.
- Meet the additional criteria specified in § 412.22(h) if it is to be classified as a satellite facility and to be excluded from the acute care hospital inpatient prospective payment system.

In the March 22, 2002 proposed rule, we proposed that we would apply the existing criteria described above for classification as a LTCH under the LTCH prospective payment system with one exception relating to the average length of stay requirement discussed in section VIII.B.2. below.

Comment: One commenter described a specific LTCH that specializes in end-of-life palliative care for advanced stage cancer patients. Because of the costs associated with this LTCH's case-mix, the commenter was concerned that the LTCH would be unable to continue to offer this type of care based on the payments it expected to receive under the LTCH prospective payment system. Therefore, the commenter requested that CMS allow the hospital to qualify as either a critical access hospital (CAH) or a cancer hospital and continue to be exempted from the acute care hospital inpatient prospective payment system and be paid on a reasonable cost basis.

Response: In order for a hospital to be classified as a CAH and not as a LTCH, the hospital would have to meet the statutory criteria for classification as a CAH in section 1820(c)(1)(B) of the Act. Similarly, a hospital would have to meet the statutory criteria for classification as a cancer hospital in section 1886(d)(1)(B)(v) of the Act to be classified as such. To the extent that a hospital does not satisfy the statutory criteria to be classified as a CAH or a cancer hospital and continues to satisfy the statutory criteria to be classified as a LTCH, the hospital will continue to be classified as a LTCH as required by the statute. Any changes in either of these criteria and the accompanying requirements would require legislative action.

Comment: Several commenters referenced existing provisions at § 412.22(f) that ''grandfather'' certain LTCHs for participation in the Medicare program and questioned how this status would be affected by the implementation of the LTCH prospective payment system.

Response: We interpret section 4417 of the BBA, codified as section 1886(d)(1)(B) of the Act and implemented under in § 412.22(f), to permit existing LTCHs that were designated LTCHs on or before September 30, 1995, and were co-located with acute care hospitals as hospitals-within-hospitals, to be exempt from compliance with § 412.22(e) concerning the ownership and control requirements for hospital-within-hospital status without losing their status as hospitals excluded from the acute care hospital inpatient prospective payment system. The ''grandfathered'' status conferred by the statute, which allowed these particular LTCHs to retain the preexisting relationships with their host hospitals, will be unaffected by the implementation of the prospective payment system for LTCHs. However, we emphasize that, for these ''grandfathered'' LTCHs to receive payment under the LTCH prospective payment system, they must still satisfy the new requirements established under the LTCH prospective payment system for the average length of stay for Medicare patients of greater than 25 days under revised § 412.23(e)(2) discussed below. Moreover, since we believe that the intent of the statute was to only exempt those pre-FY 1996 LTCHs that are hospitals-within-hospitals from the requirements of § 412.23(e), these ''grandfathered'' LTCHs will be subject to the onsite discharge and readmission policies set forth in § 412.532, in the same way that they were under the 5-percent threshold established by the TEFRA system (64 FR 41537, July 30, 1999).

Comment: Two commenters responded to the description of the universe of LTCHs in the proposed rule by suggesting that CMS require LTCHs that treat large percentages of rehabilitation patients to seek certification as IRFs. Another commenter urged CMS to require LTCHs to monitor their admission criteria to require evaluation of rehabilitation needs and that patients who predominantly need rehabilitation, without complex acute medical needs, should be excluded from admission to a LTCH. The commenter also suggested that CMS enforce an equivalence of payment between LTCHs and IRFs for patients with acute rehabilitation needs. An additional commenter suggested that LTCHs specializing in treating patients with psychiatric LTC–DRGs be required to seek certification as psychiatric facilities.

Response: Under section 1886(d)(1)(B) of the Act, the prospective payment system for acute care hospital inpatient operating costs set forth in section 1886(d) of the Act does not apply to several specified types of hospitals, including LTCHs which are defined in section 1886(d)(1)(B)(iv)(I) of the Act as ''* * * a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.'' Section 1886(d)(1)(B)(iv)(II) of the Act also provides another definition of LTCHs: specifically, a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis of neoplastic disease in the 12-month cost reporting period ending in FY 1997. Accordingly, the statute does not provide any exclusions from payment as

a LTCH based on any other criteria, such as treating rehabilitation patients or psychiatric patients. As required by the BBRA and the BIPA, we designed a prospective payment system for LTCHs, effective October 1, 2002, as a distinct classification of hospitals excluded from the acute care hospital inpatient prospective payment system. Congressional action would be required for any additional requirements or restrictions for classification as LTCHs. After a hospital qualifies as a LTCH and meets the conditions of participation set forth in existing regulations at 42 CFR 482, Subparts A through D, the hospital is free to determine the type of services it will provide. If a LTCH chooses to be treated as a particular type of hospital for Medicare payment purposes, it would have to meet the statutory criteria for that particular type of hospital.

Comment: Two commenters questioned specific aspects of the Medicare requirements for hospitals to be paid under the LTCH prospective payment system. One of the commenters suggested using the collection of information requirements established under the Paperwork Reduction Act of 1995 as a rationale for urging CMS to gather more information on LTCH patients so that CMS could develop a mandatory functional status measure for LTCH patients falling into three LTC–DRGs that the commenter identified as reflecting rehabilitation needs. The other commenter urged CMS to require the development and use of a patient assessment tool for LTCH patients classified in rehabilitation LTC–DRGs similar to the IRF patient assessment instrument (PAI).

Response: Section 123 of the BBRA and section 307 of the BIPA confers broad authority on the Secretary to design and implement a prospective payment system for LTCHs. In particular, although section 123(a)(2) of the BBRA provides that the Secretary may require LTCHs to submit such information as the Secretary requires to develop a LTCH prospective payment system, the statute contains no requirement for LTCHs to collect information on measuring an individual patient's functional status. Section 123 of the BBRA provided the Secretary with the authority to collect such information from LTCHs that may be necessary to develop the LTCH prospective payment system. The system we have developed incorporates all of the DRGs used in the acute care hospital inpatient prospective payment system. While many patients admitted to LTCHs are rehabilitation patients, most of the patients treated by LTCHs are not rehabilitation patients. Accordingly, since the IRF prospective payment system, which was developed for rehabilitation patients, incorporates functional status as an integral part of the classification system, it was necessary to collect patient functional status information. However, since, for LTCHs, we have adopted the same DRGs used for inpatient acute care hospitals, functional status is not a part of that system and, therefore, that information is not necessary to collect.

2. Change in the Average 25-Day Total Inpatient Stay Requirement

Section 1886(d)(1)(B)(iv)(I) of the Act describes a LTCH generally as ''a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.'' Thus, the statute gives the Secretary broad discretion in determining the average inpatient length of stay for hospitals for purposes of determining whether a hospital warrants exclusion from the acute care hospital inpatient prospective payment system under section 1886(d) of the Act. Existing Medicare regulations at §§ 412.23(e)(1) and (e)(2) include all hospital inpatients in this calculation of the average inpatient length of stay.

As we indicated in the March 22, 2002 proposed rule (67 FR 13430), our data revealed that approximately 52 percent of Medicare patients at LTCHs have lengths of stay of less than two-thirds of the average length of stay for the LTC–DRGs, and 20 percent have a length of stay of even less than 8 days. This means that some hospitals, while currently qualifying as LTCH by averaging non-Medicare long-stay patients to maintain a length of stay of over 25 days, do not generally furnish ''long-term care'' to their Medicare patients. In these situations, many of the hospitals' short-stay Medicare patients could be receiving appropriate services as patients at acute care hospitals. Under the LTCH prospective payment system, the LTC–DRG weights and standard Federal payment rate are based on the charges and costs of services furnished to LTCH patients, which are typically more medically complex and more costly than those furnished to acute care hospital patients.

The LTCH prospective payment system will result in higher per discharge payments for LTCHs than payments under the acute care hospital inpatient prospective payment system for patients that will group into identical DRGs under each system. Therefore, we stated that we believed that application of current policy, which factors in non-Medicare patients' lengths of stay in determining LTCH status, could result in inappropriately higher payments for those Medicare short-stay patients who happen to be treated in a LTCH instead of an acute care hospital. This is the case when a hospital does not reach the mandatory 25-day average length of stay for designation as a LTCH without non-Medicare patients included in the calculation. Therefore, we proposed that if a hospital were not treating Medicare patients that, on average, require the more costly services offered at LTCHs that differentiate these hospitals from acute care hospitals, Medicare payments would be determined under the acute care hospital inpatient prospective payment system. Such payments would be lower for each acute care DRG than for each LTC–DRG, reflecting the lower costs of acute care hospitals.

Under the current reasonable cost-based reimbursement system, Medicare payments to LTCHs are commensurate with the actual reasonable costs incurred by the hospital. Therefore, under that system, Medicare payments for shorter lengths of stay patients reflect the lower costs of those patients. However, under the LTCH prospective payment system, which is based on average costs of treatment for particular diagnosis, the hospital will receive prospective payments based on the average costs for these much shorter length of stay patients. Even under our short-stay outlier policy, as described in section X.C. of this final rule, the hospital will have the opportunity to be paid 120 percent of its costs.

Therefore, in the March 22, 2002 proposed rule, we proposed to include the hospital's Medicare patients, but not non-Medicare patients, in determining the average inpatient length of stay (§ 412.23(e)(2)) for purposes of section 1886(d)(1)(B)(iv)(I) of the Act.

Our proposal was based on a belief that there would be a strong incentive for LTCHs not to admit many short-stay Medicare patients since doing so could jeopardize their status as a LTCH. Instead, those patients could receive appropriate care at an acute care hospital and the care will be paid under the acute care hospital inpatient prospective payment system. Furthermore, our proposal to change the methodology for determining the average inpatient length of stay to be based only on Medicare patients was consistent with the intent of our proposed policies to make different payments for cases of very short-short stay discharge and short-stay outliers. These proposed policies also were intended to discourage LTCHs under the prospective payment system from treating Medicare patients who do not

require the more costly resources of LTCHs and who could reasonably be treated in acute care hospitals.

We received a substantial number of comments on the proposed change to the average 25-day length of stay requirement.

Comment: The majority of the commenters endorsed the proposed policy of counting only Medicare patients in determining the 25-day average length of stay. However, the commenters believed that the calculation should be based on total days that a Medicare patient received care in the LTCH rather than just the days for which the cost of care was covered by Medicare (that is, ''covered days'').

Since a high percentage of LTCH patients are admitted following inpatient stays at acute care hospitals, the commenters expressed concern that some patients could exhaust their Medicare coverage before it was clinically appropriate for them to be discharged from the LTCH. The commenters were concerned that if only Medicare-covered days were counted in the average length of stay calculation for qualification as a LTCH, it would behoove a hospital to treat only those Medicare patients who were far from exhausting their Part A benefits and, concomitantly, to refuse admittance to patients with limited or no remaining Medicare days, regardless of the clinical appropriateness of such an admission in order to retain (or attain) LTCH status. The commenters gave the following as an example: If only covered days were counted in the qualification formula, a Medicare patient who was actually in the LTCH for 30 days but only had 4 days of Medicare Part A coverage remaining upon admittance to the LTCH, for purposes of the formula, would count as a patient stay of 4 days. Thus, the commenters pointed out, while the hospital would be treating Medicare patients who have an average length of stay of over 25 days, a number of these admissions could jeopardize the hospital's payment under Medicare as a LTCH.

Two commenters also noted that, under existing policy which counted all patient days, Medicare noncovered days were not excluded from the 25-day average length of stay calculations. They urged us to continue this policy while restricting the actual patient count to Medicare patients.

Response: As noted above, our data analyses disclosed that a significant number of Medicare patients at LTCHs were treated for considerably less time than the average length of stay. In many cases, in order to maintain the current 25-day length of stay requirement, these shorter Medicare stays were being offset by much longer stays of non-Medicare patients. Given the Secretary's broad discretion under section 1886(d)(1)(B)(iv)(I) of the Act to define the 25-day average length of stay, we proposed to revise § 412.23(e)(1) to limit the average inpatient length of stay calculation solely to Medicare patients. Our purpose was to ensure that payments under the LTCH prospective payment system are based on the charges and costs of treating Medicare patients with the high medical complexity associated with LTCHs, and not the costs of providing highly complex care to non-Medicare patients.

We do not wish to create any barriers for LTCHs to treat Medicare patients who require long-term hospitalization and who could benefit from the particular treatment modalities available in some LTCHs. LTCHs exist as a provider-type in order to treat Medicare patients requiring complex long-term, hospital-level care. We believe that a hospital's right to qualify for payments under the prospective payment system for LTCHs should result from the actual provision of clinically appropriate care to Medicare LTCH patients rather than on the number of Medicare covered days remaining for any of their patients during any particular cost reporting period. Accordingly, in this final rule, we are maintaining our current policy of counting all patient stays and revising §§ 412.23(e)(2) and (e)(3) to specify that we will count *all* the days in a Medicare patient's stay (covered and noncovered days), that is, total days, in the LTCH in calculating whether a LTCH meets the average 25-day length of stay requirement.

Comment: Two commenters disagreed with the proposed policy change and requested CMS to retain the policy of counting all patient days in the calculation. One of the commenters noted that, based on its experience, its non-Medicare patients required more complicated treatment than its Medicare patients and, therefore, for a hospital's status to hinge on the shorter length of stay of Medicare patients contradicted the purpose of a LTCH.

Response: We reiterate that section 1886(d)(1)(B)(iv)(I) of the Act confers broad authority on the Secretary to determine the parameters of the ''average inpatient length of stay of greater than 25 days.'' We interpret the provisions to apply to payment for patients who are provided care under Medicare. We believe that the redefinition of the average length-of-stay criterion as limited solely to Medicare patients at LTCHs conforms to the requirements of section 123 of the BBRA for the development of a prospective payment system for payment of inpatient hospital services furnished by LTCHs ''under the [M]edicare program.'' Furthermore, nothing in this revised criterion prevents or discourages LTCHs from accepting non-Medicare patients. Should a LTCH be unable to retain its status within this payment category because a significant number of its Medicare patients do not require long-term hospital-level care, we believe that it is reasonable for the facility to reevaluate the appropriateness of its admission policies. Notwithstanding any changes in the type of patients treated at the hospital, the hospital will still be able to admit and be paid by Medicare as an acute care hospital.

Comment: Several commenters expressed concern about the length of time an existing LTCH would have to comply with the proposed revised average 25-day length of stay requirement before its ability to participate in Medicare as an LTCH would be jeopardized and questioned compliance monitoring. The commenters suggested that CMS institute a ''grace period'' for LTCHs to comply with the new requirement.

Response: The revised definition for an average length of stay, which is determined on Medicare inpatients only, is effective for LTCH hospitals starting with their first cost reporting period that begins on or after October 1, 2002. We have directed our fiscal intermediaries to determine whether existing LTCHs qualify for payments under the LTCH prospective payment system according to the revised criteria after October 1, 2002. In addition, we have directed our fiscal intermediaries to notify LTCHs about whether a LTCH qualifies for payment under the LTCH prospective payment system before the start of the LTCH's next cost reporting period.

Under existing policy at § 412.22(d), changes in a hospital's status are effective at the beginning of the next cost reporting period and are effective for the entire cost reporting period. Therefore, for example, in the case of an existing LTCH with a cost reporting period beginning on October 1, 2002, for which a LTCH's fiscal intermediary determined on January 15, 2003, that the LTCH did not meet the new 25-day average length of stay criterion for the 12-month period for which the fiscal intermediary or CMS has the most recent cost report data, the LTCH would be paid as a LTCH until September 30, 2003. The LTCH would then lose its LTCH status as of October 1, 2003 unless for the 6 months prior to

September 30, 2003, the LTCH demonstrated that it had an average length of stay of greater than 25 days for its Medicare inpatients under existing § 412.23(e)(3)(ii), which we are not revising. If the hospital was able to demonstrate that during the 6 months prior to September 30, 2003, that it had an average Medicare length of stay of greater than 25 days, the hospital would continue to be paid as a LTCH even after October 1, 2003 (§ 412.23(e)(3)(ii)). Therefore, notification by the LTCH's fiscal intermediary following the effective date of the LTCH prospective payment system on October 1, 2002, will permit LTCHs that would not qualify based on their most recent cost report data to adapt to the revised length of stay criterion before reaching the actual point where they would cease to be paid as LTCHs.

As a further example, a LTCH that begins its next cost reporting period on January 1, 2003 will be notified about whether it satisfies the revised average length of stay criterion effective on October 1, 2002, for the 12-month period for which the fiscal intermediary or CMS has the most recent cost report data, by its fiscal intermediary after the start of its fiscal year on January 1, 2003. In the event that a LTCH's most recent cost report indicates that it would not qualify, the LTCH would still be paid as a LTCH from January 1, 2003 through December 31, 2003. The hospital would lose its LTCH status as of January 1, 2004, and be paid under the acute care hospital inpatient prospective payment system unless it provides data to its fiscal intermediary for the 6-month period immediately preceding December 31, 2003, which demonstrate that it satisfies the average length of stay criterion (§ 412.23(e)(3)(ii)).

Through application of the existing regulations described above, we believe that LTCHs are granted sufficient time to adapt to the new length of stay requirements for payment under the LTCH prospective payment system and we do not believe that it is necessary or appropriate to grant an additional ''grace period'' for this purpose.

Comment: One commenter noted that juxtaposing the proposed interrupted stay policy with the revised average 25-day length of stay criterion could be problematic in determining whether a hospital continued to qualify for Medicare payments as a LTCH. The commenter described the following scenario: a patient, after a 100-day stay at a LTCH, is discharged to an acute care hospital 5 days before the end of a Medicare fiscal year that resulted in an average length of stay of 25.01 days. The patient is then readmitted at the start of the next Medicare fiscal year to the LTCH as an interrupted stay from the acute care hospital. Under our proposed interrupted stay policy, we would treat both stays as one discharge from the LTCH. Therefore, the patient's 100-day stay from the prior Medicare cost reporting period would be counted in the following year's cost reporting period and the LTCH's average Medicare inpatient length of stay for the prior cost reporting period would drop below 25 days. The commenter questioned whether, for purposes of calculating the average 25-day length of stay, the LTCH be at risk of losing LTCH status if the average length of stay for the previous Medicare fiscal year fell below the 25 days.

Response: Under our proposed interrupted stay policy, a LTCH patient who is discharged to an acute care inpatient hospital, an IRF, or a SNF and then returns to the same LTCH would be treated as an interrupted stay (with one LTC–DRG payment) or as a new admission (with two separate LTC–DRG payments) depending on the patient's length of stay compared to the average length of stay and the standard deviation for the acute care hospital inpatient prospective payment system DRG, the IRF combination of the CMG and the comorbidity tier, or 45 days for all Medicare SNF cases.

We have revised the proposed interrupted stay policy in this final rule. The interrupted stay policy set forth in section X.E. of this final rule provides that the lengths of stay at acute care hospitals and IRFs are based on one standard deviation from the average length of stay for all patients in acute hospitals and IRFs, respectively. Therefore, in this final rule, the interrupted stay policy for acute care hospitals, IRFs, and SNFs are based on the same formula. Under this revised policy, the patient stay described by the commenter would be an interrupted stay if the patient returned to the LTCH from the acute care hospital before reaching the 9-day threshold for acute care hospitals. The readmission to the LTCH would be considered as a resumption of the treatment from the original admission rather than as a second admission. Therefore, the patient's original discharge from the LTCH at the end of the fiscal year would not count as a discharge for length of stay calculations for that fiscal year because the discharge to the acute care hospital is merely the point at which the stay was interrupted, and the patient ultimately returned to the same LTCH within a specified fixed day period. For both Medicare payment determinations under the interrupted stay policy and length of stay calculations, the discharge for that patient would occur when the patient is discharged from the LTCH during the next fiscal year. This is the case since the calculation of a LTCH's average length of stay for purposes of qualifying as a LTCH is based on discharges during a cost reporting period. Consequently, in accordance with the requirements at § 412.23(e), while the days of care provided to this patient would be included in the length of stay calculation in the first year, the discharge for that patient with the 100-day stay would be counted in the length of stay calculation for the subsequent fiscal year.

We understand the commenter's concern that such a scenario could jeopardize the hospital's ability to participate in the Medicare program as a LTCH. We emphasize that, under the policy described in the previous response, this is not the case.

The procedure by which a LTCH will be evaluated by its fiscal intermediary to determine whether it will qualify as a LTCH under the revised 25-day average length of stay criterion is the same procedure presently employed under the TEFRA system. Following the review of the LTCH's most recent cost report by the fiscal intermediary, which for FY 2003 will occur following the effective date of the LTCH prospective payment system, the LTCH will be notified whether, based on that cost report, it satisfies the greater than 25-day average length of stay requirement for its Medicare patients for payment as a LTCH under the LTCH prospective payment system. As noted above, the LTCH will become subject to this revised criterion for its first cost reporting period beginning on or after October 1, 2002.

A LTCH with a cost reporting year of October 1, 2002 through September 30, 2003 that does not qualify as a LTCH under the new criterion based on its FY 2001 cost report will continue to be paid as a LTCH until October 1, 2003. The hospital will then be paid as an acute care hospital unless it demonstrates that, during the 6 months prior to October 1, 2003, it had an average Medicare inpatient length of stay of greater than 25 days (§ 412.23(e)(3)(ii)). Therefore, under the scenario presented by the commenter in which the LTCH that failed the 25-day average length of stay requirement for its Medicare patients during one fiscal year because the pivotal discharge for that year was forced into the next year by the interrupted stay policy, the LTCH would not lose its designation if it could present 6 months of data indicating compliance with the new requirement

for the period preceding the cost reporting period for which it would lose its designation.

Comment: Three commenters recommended that CMS change the day requirement in the average length of stay criterion. One commenter recommended lowering the 25 days to 20 days. Another commenter recommended requiring that only 95 percent of all LTCHs meet the 25-day requirement. The third commenter recommended changing the length of stay criterion so that it is computed based on the median length of stay rather than the average length of stay.

Response: 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'' (emphasis added). Although the Secretary has been granted broad authority in defining how the statute is implemented, section 1886(d)(1)(B)(iv)(I) of the Act clearly and unambiguously establishes the 25-day standard and the use of the average in the computation. The changes suggested by the commenters would require legislative action.

Comment: One commenter questioned why CMS decided to limit the average 25-day length of stay criterion to Medicare patients only, but in establishing the prospective payment system for IRFs, the ''75 percent rule'' was applied to all patients, regardless of payer source.

Response: The only requirement imposed by section 1886(d)(1)(B)(iv)(I) of the Act that differentiates a LTCH from another acute hospital is the average length of stay requirement. In addition, as stated earlier, our data revealed that a considerable proportion of Medicare patients are not receiving ''long-term care'' at LTCHs. The revision was proposed on the basis of the calculation of the greater than 25-day length of stay requirement, but did not restrict the patient census of the LTCH. Notwithstanding the proposed revision, a LTCH is free to admit and treat any patient it believes is clinically appropriate. Should that LTCH admit a short-stay Medicare patient, under this final rule the stay will be paid for under the short-stay outlier policy (section X.C. of this preamble and § 412.529 of the final regulations).

The objective of our revised policy is to establish a payment system for the care of Medicare patients at LTCHs that truly require the type of care and resources available at LTCHs and, therefore, incur costs to the Medicare system in accordance with such treatment. Should a LTCH admit many short-stay Medicare patients, it could well jeopardize its ability to participate under Medicare as a LTCH.

We are currently reviewing criteria for qualifying as an IRF, including the 75-percent rule, to determine whether any changes to the policy or administrative procedures for enforcing it are appropriate. Accordingly, rather than making changes to the types of patients used in calculating the 75 percent criterion at this time, we intend to address this issue as it affects IRFs when we address all of the qualifying criteria.

Comment: One commenter pointed out that as a LTCH improves its efficiency under the LTCH prospective payment system, the result could be shorter lengths of stay for Medicare patients, an outcome that would jeopardize the hospital's status as a LTCH.

Response: We agree with the commenter that as a LTCH becomes more efficient, its average length of stay may be reduced. Our experience with implementing other prospective payment systems under Medicare encourages us to believe that, even under circumstances of providing treatment for the most severely ill patient, quality of care can be preserved and even be improved once hospitals adapt to such a payment system. Our data, reflecting LTCHs throughout the country as well as acute care hospitals that treat patients who could also be treated in LTCHs, reveal a range of lengths of stay for the same diagnoses. If this reduction brings the hospital's average length of stay to 25 days or less, the hospital would lose its LTCH status. However, the requirements for both the DRG-based prospective payment system and the greater than 25-day average length of stay criterion are statutory. Any changes in these requirements must be pursued at the legislative level.

Comment: One commenter suggested that, since the proposed systems design for the LTCH prospective payment system was based on data gathered from all hospitals identified in our provider files as LTCHs, if CMS changed the criteria for payment under Medicare from a consideration of average lengths of stay for all patients to those of only Medicare patients, data from LTCHs that would lose their designation under this change should be excluded from payment modeling.

Response: Payment modeling for the LTCH prospective payment system was based on an analysis of data from existing LTCHs on their Medicare patients, costs, charges, and payments. The commenter appears to presume the following: That as of October 1, 2002, existing LTCHs not qualifying under the revised average length of stay requirement would lose their designation as LTCHS and that data from these hospitals should therefore not be included in payment simulations and policy determinations. We disagree with the commenter's points. The revised length of stay policy is a requirement of the prospective payment system for LTCHs and will become effective for any LTCH when that hospital becomes subject to the prospective payment system, that is, when the LTCH starts its first cost reporting period that begins on or after October 1, 2002. It is not appropriate to determine whether a hospital meets the new length of stay criterion for our modeling purposes. Changes in a hospital's status are effective only at the beginning of a cost reporting period and are effective for the entire cost reporting period under existing § 412.22(d). For example, if an existing LTCH with a cost reporting period that begins on October 1, 2002, does not meet the 25-day average length of stay criterion according to its fiscal intermediary's determination, the LTCH would not lose its LTCH status earlier than October 1, 2003, the beginning of its next cost reporting period. If in the 6 months prior to October 1, 2003, the hospital demonstrated an average length of stay of greater than 25 days for its Medicare patients, the hospital would continue to be paid as a LTCH even after October 1, 2003. We believe that LTCHs have a strong incentive to reevaluate their admission policies based on this new criterion, and that many of the LTCHs that presently may not meet the new requirement may achieve compliance when required and not lose their LTCH status. In addition, including the data from those hospitals that currently treat Medicare patients with an average length of stay of 25 days or less is appropriate. As explained in section X.A.2. of this preamble, in calculating the relative weights for each LTC–DRG, we adjusted the weight for short-stay outlier cases based on the average costs for that LTC–DRG. This adjustment allowed us to appropriately include more cases in the calculation of the LTC–DRG relative weight. Accordingly, we disagree with the commenter and did not remove data from those hospitals in developing the LTCH prospective payment system.

After consideration of public comments received on the proposed change in the average 25-day length of stay requirement for LTCHs, in this final rule we are adopting the proposed change as final with one clarification. Under this final rule, we will determine

the average inpatient length of stay in a LTCH, for purposes of section 1886(d)(1)(B)(iv)(I) of the Act, for the hospital's Medicare patients, but not non-Medicare patients. In addition, we are clarifying that the hospital's 25-day average Medicare inpatient length of stay includes all inpatient days (covered and noncovered) of Medicare patients' stays at the LTCH.

In addition, as we indicated in the proposed rule and as authorized under the statute, we are changing the methodology for determining the average inpatient length of stay for purposes of section 1886(d)(1)(B)(iv)(I) of the Act, but we are not changing the methodology for purposes of section 1886(d)(1)(B)(iv)(II) of the Act (§ 412.23(e)). For purposes of the latter provision (subclause (II)), we are retaining the current methodology (which includes non-Medicare as well as Medicare patients) because we believe that the considerations underlying the change in methodology for subclause (I) are not present under subclause (II). As discussed above, we are revising the methodology for purposes of the general definition of LTCH under subclause (I) because under the current methodology some hospitals that might not warrant exclusion from the acute care hospital inpatient prospective payment system have nevertheless obtained status as excluded hospitals. We believe that excluding non-Medicare patients in determining the average inpatient length of stay for purposes of subclause (I) would be more appropriate in identifying the hospitals that warrant exclusion under the general definition of LTCH in subclause (I). However, in enacting subclause (II), Congress provided an exception to the general definition of LTCH under subclause (I), and we have no reason to believe that the change in methodology for determining the average inpatient length of stay would better identify the hospitals that Congress intended to exclude under subclause (II).

We will monitor the types of hospitals that will qualify as LTCHs based on the revised 25-day length of stay criterion. It is possible that hospitals that currently qualify as either rehabilitation hospitals or psychiatric hospitals will now also qualify as LTCHs under the revised criterion and will choose to be LTCHs and be paid as LTCHs. We also will monitor whether the change in methodology for measuring the average length of stay in LTCHs will result in unanticipated shifts of patients to IRFs and psychiatric facilities. If this pattern of behavior is observed, we will address it at that time.

3. LTCHs Not Subject to the LTCH Prospective Payment System

In this final rule, we are specifying that only hospitals qualifying as LTCHs under the revised criteria described in section VIII.B.1. and 2. of this preamble and in revised § 412.23(e) by October 1, 2002, will be subject to the LTCH prospective payment system. Our treatment of new hospitals first qualifying as LTCHs on or after October 1, 2002, is addressed in section X.O. of this final rule.

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

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

C. Limitation on Charges to Beneficiaries

In accordance with existing regulations and for consistency with other established hospital prospective payment systems policies, we are specifying in this final rule that a LTCH may not charge a beneficiary for any services for which a full DRG payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital will be paid for those services under the LTCH prospective payment system (§ 412.507).

In the proposed rule under § 412.507(b), we specified that a LTCH receiving a prospective payment for a covered hospital stay may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of the existing regulations, and for items or services specified under § 489.20(a) of the existing regulations.

Comment: Some commenters expressed concern with the interaction of the proposed reduced per discharge payments for both very short-stay discharges and short-stay outliers and the requirements at proposed § 412.507 of the regulations which limit the amount the LTCH may bill the beneficiary and the effect this will have on Medigap payments.

Response: We have reviewed our proposed policy and have concluded that the language in proposed § 412.507 requires clarification. We proposed that beneficiaries who had exhausted their Part A coverage prior to two-thirds of the average length of stay (changed in this final rule to five-sixths of the geometric average length of stay) for each LTC–DRG to receive payments as short-stay outliers. The commenters' questions regarding the interaction of the short-stay outlier payment policy and Medigap indicate that the commenters also understood the intent of our short-stay policy. However, because the regulation text may not clearly indicate our intent, we are revising it to reflect this intended policy.

We are revising the language at § 412.507(b) to state that a LTCH may not bill the patient for more than the deductible and coinsurance amounts if the Medicare payment to the LTCH is the full LTC–DRG payment amount. However, if the Medicare payment is for a short-stay outlier case that is less than the full LTC–DRG payment amount, the LTCH may also charge the beneficiary for services for which the costs of those services or the days those services were provided were not a basis for calculating the Medicare short-stay outlier payment.

Proposed § 412.507(b) had stated that ''A long-term care hospital that receives payment * * * for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter, and for items and services as specified under § 489.20(a) of this chapter.'' We are revising the language in the regulation, since that language could appear to have provided for payment of the *full* LTC–DRG payment (with no adjustment for a short-stay outlier) as long as the Medicare beneficiary had a stay that included at least one covered day. However, payments to LTCHs are adjusted for short-stay outliers. By revising § 412.507(b) in this final rule, we are clarifying the provision so that Medigap will be responsible for payment for the costs of those ''services provided during the stay that were not the basis for the short-stay payment.''

Comment: Several commenters have expressed concern that if Medigap insurers are only required to pay outlier rates once a patient has exhausted the Medicare-covered days (as is the case

under the existing acute care hospital inpatient prospective payment system and the IRF prospective payment system), LTCHs will most likely be seriously underpaid. The commenters asked for clarification that, under the LTCH prospective payment system, Medigap insurers are required to pay more than a mere continuation of the outlier rate since the full DRG payment will not be made in the case of an admission that occurs near the point at which the patient would exhaust his or her lifetime reserve days.

Specifically, the commenters asked that CMS issue a program memorandum to State insurance commissioners and issuers (commonly referred to as a Medigap bulletin) clarifying Medigap insurers' payment responsibilities under the new LTCH prospective payment system.

Response: During any covered Medicare Part A hospital benefit period, from days 61 through 90, every Medigap policy must pay the hospital coinsurance amount of one-fourth of the hospital deductible per day. For every lifetime reserve day (91st to the 150th day) that the policyholder uses, the Medigap insurer must pay the coinsurance amount of one-half of the hospital deductible. If the policyholder exhausts his or her lifetime reserve days, the Medigap insurer is required to provide ''coverage of the Medicare Part A eligible expenses for hospitalization paid at the DRG day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.'' (Section 8.B(3) of the Model Regulation for Medicare Supplement Policies developed by the National Association of Insurance Commissioners (NAIC), which is incorporated by reference into section 1882 of the Act.) The term ''Medicare eligible expenses'' is defined in the NAIC Model Regulation as expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

We have consistently interpreted this language to require that the Medigap insurer make payments at the rate Medicare would have paid, had Medicare Part A hospital days not been exhausted. Under the acute care hospital inpatient prospective payment system, even if a patient has only one day of Medicare coverage remaining at the time of admission, Medicare pays the full DRG payment amount. A Medigap insurer would simply be responsible for outliers, if any. Similarly, since patients who exhaust their Medicare covered days are frequently in outlier status already, the Medigap insurer's responsibility is simply to continue paying what Medicare had been paying on the last day of coverage (that is, the outlier amount).

However, under the LTCH prospective payment system, the payment methodology is more complex. The LTC–DRG payment amount is based, in part, on how long the patient is expected to stay in the LTCH. The payment to the LTCH is determined after the patient is discharged, and will be reduced if the patient is discharged significantly earlier than the expected length of stay. Such stays are referred to as ''short-stay outliers.'' The fiscal intermediary follows the formulas specified in section X.C. of this preamble to determine the actual payment amount, which is expressed in terms of an adjustment to the LTC–DRG payment.

Accordingly, if a patient with a Medigap policy exhausts Medicare covered days before being discharged from a LTCH, the only way to determine the ''appropriate standard of payment'' for which the Medigap insurer is responsible is to use the same methodology used by Medicare. If the beneficiary exhausted Medicare benefits while he or she is still within the period of time considered to be a ''short-stay outlier,'' Medicare will make payment to the LTCH as if it were a short-stay, regardless of the length of stay. This means that the payment that happens to be attributed to the last day of Medicare coverage is not an accurate basis for calculating the Medigap insurer's responsibility. It may be more, or less, than the appropriate LTC–DRG payment ultimately applicable to the full stay. The Medigap insurer should use the LTCH methodology to calculate the amount Medicare would have paid for the full hospital stay, and deduct the amount paid by Medicare for the days prior to the exhaustion of benefits.

Comment: One commenter expressed concern that State Medicaid programs might determine the amount of Medicaid payment based on what Medicare would pay under the very short-stay policy. The existing regulations at § 447.205(b)(1) allows a State to use Medicare level of reimbursement without public notice. The commenter was concerned that very short-stay rates of payment could migrate to the Medicaid program and be used to pay hospitals without regard to the Medicaid average length of stay of a patient.

Response: Medicaid is a joint Federal and State program that assists with medical costs for people with low incomes and limited resources. Under the Medicaid program, States have the option to pay based on Medicare's payment principles or other alternative methodologies, subject to the overall Medicare upper payment limitation. While, for example, some State Medicaid programs may adopt the Medicare payment policy for short-stay cases, the Medicare program has no authority to dictate payment policy to State Medicaid programs. The commenter raised a concern with the proposed very short-stay discharge payment policy. As discussed earlier in this final rule, we have eliminated the very short-stay policy and included those stays in our short-stay policy in this final rule. The final short-stay policy will pay for those cases with lengths of stay at or below five-sixths of the geometric average length of stay for the LTC–DRG at the least of: (1) 120 percent of the LTC–DRG specific per diem; (2) 120 percent of the cost of the case; or (3) the full LTC–DRG payment.

In accordance with existing regulations and for consistency with other established hospital prospective payment systems policies, we are specifying in this final rule that a LTCH may not charge a beneficiary for any services for which a full LTC–DRG payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital will be paid under the LTCH prospective payment system (§ 412.507).

D. Medical Review Requirements

In accordance with existing regulations at §§ 412.44, 412.46, and 412.48 and for consistency with other established hospital prospective payment systems policies, we proposed and are specifying in this final rule that a LTCH must have an agreement with a Quality Improvement Organization (QIO) (formerly, a Peer Review Organization (PRO)) to have the QIO review, on an ongoing basis, the medical necessity, reasonableness, and appropriateness of hospital admissions and discharges and of inpatient hospital care for which outlier payments are sought; the validity of the hospital's diagnostic and procedural information; the completeness, adequacy, and quality of the services furnished in the hospital; and other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries (§ 412.508(a)). In addition, we are requiring that, because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record, physicians must

complete an acknowledgement statement to that effect. We are applying the existing hospital requirements for the contents and filing of the physician acknowledgment statement (§ 412.508(b)).

Also, as proposed and now codified in this final rule, consistent with existing established hospital prospective payment system policies, if CMS determines, on the basis of information supplied by the QIO, that a hospital has misrepresented admissions, discharges, or billing information or has taken an action that results in the unnecessary admission or multiple admission of individuals entitled to Part A benefits or other inappropriate medical or other practices, CMS may deny payment (in whole or in part) for LTCH hospital services related to the unnecessary or subsequent readmission of an individual or require the hospital to take actions necessary to prevent or correct the inappropriate practice. Notice and appeal of a denial of payment will be provided under procedures established to implement section 1155 of the Act. In addition, a determination of a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system will be referred to the Department's Office of Inspector General, for handling in accordance with 42 CFR 1001.301.

E. Furnishing of Inpatient Hospital Services Directly or Under Arrangements

In accordance with existing regulations at § 414.15(m) and for consistency with other established hospital prospective payment systems policies, a LTCH must furnish covered services to Medicare beneficiaries either directly or under arrangements. Under § 412.509, the LTCH prospective payment will be payment in full for all covered inpatient hospital services, as defined in § 409.10 of the existing regulations. We will not pay any provider or supplier other than the LTCH for services furnished to a Medicare beneficiary who is an inpatient of the LTCH, except for those services that are not included as inpatient hospital services that are listed under existing § 412.50 (that is, physicians' services that meet the requirements of § 415.102(a) for payment on a fee schedule basis; physician assistant services as defined in section 1861(s)(2)(K)(i) of the Act; nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act; certified nurse midwife services, as defined in section 1861(gg) of the Act; qualified psychologist services, as defined in section 1861(ii) of the Act; and services of an anesthetist, as defined in § 410.69).

F. Reporting and Recordkeeping Requirements

In this final rule, we are imposing the same recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of the existing regulations on all LTCHs that will participate in the LTCH prospective payment system (§ 412.511).

G. Transition Period for Implementation of the LTCH Prospective Payment System

In this final rule, we are providing for a 5-year transition period from cost-based reimbursement to fully Federal prospective payment for LTCHs as discussed in section X.N. of this preamble. During this period, two payment percentages will be used to determine a LTCH's total payment under the prospective payment system. The blend percentages are as follows:

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

Therefore, for a cost reporting period beginning on or after October 1, 2002, and before October 1, 2003, the total prospective payment will consist of 80 percent of the amount based on the current reasonable cost-based reimbursement system and 20 percent of the Federal prospective payment rate. The percentage of payment based on the LTCH prospective payment Federal rate will increase by 20 percent and the reasonable cost-based reimbursement rate percentage will decrease by 20 percent for each of the remaining 4 fiscal years in the transition period. For cost reporting periods beginning on or after October 1, 2006, Medicare payment to LTCHs will be determined entirely under the Federal prospective payment system methodology. Furthermore, LTCHs subject to the blend have the option to elect to be paid 100 percent of the Federal rate and not be subject to the 5-year transition.

Section X.N. of this final rule contains a detailed description of our payment policies during the 5-year transition period, the public comments received on our proposal and our responses to those comments, and a discussion of changes in the claims processing procedures for an interim period of October 1, 2002 until the date of the systems implementation, because of a delay in system changes necessary for us to accommodate claims processing under the LTCH prospective payment system.

H. Implementation Procedures

In the March 22, 2002 proposed rule, we proposed procedures for implementing the LTCH prospective payment system. Section X. of this final rule contains more details on the application of these procedures. In summary, upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). Under a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, electronic health care claims, including Medicare claims, will be required to be in the new national standard claims format and medical data code sets in accordance with regulations at 45 CFR Parts 160 and 162. Beginning on October 16, 2002, a LTCH that is required to comply with the HIPAA Administrative Simplification Standards and that has not obtained an extension in compliance with the Administrative Compliance Act (Public Law 107–105) must comply with the standards at 42 CFR 162.1002 and 45 CFR 162.1102 and submit the completed claims form to its Medicare fiscal intermediary. The Medicare fiscal intermediary will enter the information into its claims

processing systems and subject it to a series of edits called the Medicare Code Editor (MCE). This editor is designed to identify cases that will require further review before classification into a LTC–DRG (described in section X. of this final rule).

After screening through the MCE, each claim will be classified into the appropriate LTC–DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is specialized computer software based on the GROUPER utilized by the acute care hospital inpatient prospective payment system, which was developed as a means of classifying each case into a DRG on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). Following the LTC–DRG assignment, the Medicare fiscal intermediary will determine the prospective payment by using the Medicare PRICER program, which accounts for hospital-specific adjustments.

As provided for under the acute care hospital inpatient prospective payment system, we are providing an opportunity for the LTCH to review the LTC–DRG assignments made by the fiscal intermediary (§ 412.513(c)). A hospital will have 60 days after the date of the notice of the initial assignment of a discharge to a LTC–DRG to request a review of that assignment. The hospital will be allowed to submit additional information as part of its request. The fiscal intermediary will review that hospital's request and any additional information and will decide whether a change in the LTC–DRG assignment is appropriate. If the intermediary decides that a different LTC–DRG should be assigned, the appropriate QIO, as specified in § 476.71(c)(2), will review the case. Following this 60-day period, the hospital will not be able to submit additional information with respect to the LTC–DRG assignment or otherwise revise its claim.

Comment: One commenter requested that we allow a LTCH 90 days instead of 60 days following the date of the notice of the initial assignment of a discharge to a LTC–DRG to request a review of that assignment during the 5-year phasein of the prospective payment system.

Response: We do not believe that an extension of the 60-day window for a LTCH to request a review of the LTC–DRG assignment by the fiscal intermediary is warranted. The ICD–9–CM coding system, on which the discharge from the LTCH will be based, has been in use in the United States since 1979, and all hospitals have been required to use this system for submission of Medicare claims. The patient classification system (LTC–DRGs) that we have chosen for the LTCH prospective payment system is based on the existing DRG system for acute care hospitals, which is familiar to coders, physicians, and providers. In addition, the timeframe is consistent with the existing 60-day timeframe allowed under the acute care hospital inpatient prospective payment system for hospitals to request review of DRG assignments by the fiscal intermediary (§ 412.60(d)). We do not believe that any change in the timeframe is warranted here because the provider is a LTCH.

As discussed in detail in section X.N. of this final rule, we will not have in place before January 1, 2003, the standard computer systems changes necessary to accommodate claims processing and payment under the LTCH prospective payment system. However, beginning October 16, 2002, we are requiring all LTCHs that are required to comply with the HIPAA Administrative Simplification Standards and that have not obtained an extension in compliance with the Administrative Compliance Act, Public Law 107–105, to submit their claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1102 to their fiscal intermediaries using the ICD–9–CM coding. We intend that, as of January 1, 2003, the fiscal intermediary will reconcile the payment amounts that have been made to LTCHs for all covered inpatient hospital services furnished to Medicare beneficiaries from cost reporting periods that begin on or after October 1, 2002 until the date of the systems implementation, with the amounts that are payable under the LTCH prospective payment methodology. We will issue specific operational instructions to fiscal intermediaries and providers for completing and submitting Medicare claims under the LTCH prospective payment system through a Medicare Program Memorandum prior to the effective date of this final rule.

Although our computer systems will continue to make payments as in the past for an interim period after October 1, 2002, Medicare payments to LTCHs will be reconciled after January 1, 2003, based on the LTC–DRGs as determined by the ICD–9–CM codes recorded on the patient claims. Therefore, we urge LTCHs to focus on improved coding practices, which are addressed in section IX.E. of this final rule.

In proposed § 412.535, we proposed a schedule for publishing information on the LTCH prospective payment system for each fiscal year in the **Federal Register**, prior to the start of each fiscal year, on or before August 1. This cycle coincides with the statutorily mandated publication schedule for the acute care hospital inpatient prospective payment system. Section 1886(e)(5)(A) of the Act requires that, for the acute care hospital inpatient prospective payment system, the proposed rule be published in the **Federal Register** ''not later than the April 1 before each fiscal year; and the final rule, not later than the August 1 before such fiscal year.'' The Act imposes no such publication schedule for the LTCH prospective payment system. Therefore, in order to avoid concurrent publication of annual rules for these two systems, for purposes of administrative feasibility and efficiency, we will be considering a change in the publication schedule for updating the LTCH prospective payment system to July 1 of each year. We will address this issue in a future proposed rule.

IX. Long-Term Care Diagnosis-Related Group (LTC–DRG) Classifications

Section 307(b)(1) of Public Law 106–554 requires that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH prospective payment system] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data.'' The LTC–DRG-based patient classification system we describe in this section is based on the existing CMS–DRG system used in the acute care hospital inpatient prospective payment system. As required by section 307(b)(1) of Public Law 106–554, we examined the feasibility and the impact of basing payment on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients. Therefore, an overview of pertinent facts about the existing CMS–DRG system is essential to an understanding of the LTC–DRGs that are employed in the LTCH prospective payment system.

As discussed below, we proposed the implementation of LTC–DRGs as a patient classification system for the LTCH prospective payment system. The LTC–DRGs classify patient discharges based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. We began the development of the LTC–DRGs system described in our proposed rule by using the CMS–DRGs that are currently used in the acute care hospital inpatient prospective payment system with the

most recent data available from the FY 2000 MedPAR file. For this final rule, we used data from the FY 2001 MedPAR file. In a departure from the acute care hospital inpatient prospective payment system, we also proposed the concept of the use of low volume LTC–DRGs (less than 25 LTCH cases) in determining the LTC–DRG weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals.

A. Background

The design and development of DRGs began in the late 1960s at Yale University. The initial motivation for developing the DRGs was the creation of an effective framework for monitoring the quality of care and the utilization of services in a hospital setting. The first large-scale application of the DRGs as a basis for payments was in the late 1970s in New Jersey. The New Jersey State Department of Health used DRGs as the basis of a prospective payment system in which hospitals were reimbursed a fixed DRG-specific amount for each patient treated. In 1972, section 223 of Public Law 92–603 originally authorized the Secretary to set limits on costs reimbursed under Medicare for inpatient hospital services.

In 1982, section 101(b)(3) of Public Law 97–248 required the Secretary to develop a legislative proposal for Medicare payments to hospitals, SNFs, and, to the extent feasible, other providers on a prospective basis. (See the September 1, 1983 **Federal Register** (48 FR 39754).) In 1983, Title VI of Public Law 98–21 added section 1886(d) to the Act, which established a national DRG-based hospital prospective payment system for Medicare inpatient acute care services. (See the January 3, 1984 **Federal Register** (49 FR 234).)

B. Historical Exclusion of LTCHs

Since the hospital inpatient DRG system had been developed from the cost and utilization experience of short-term, acute care hospitals, it did not account for the resource costs for the types of patients treated in hospitals such as rehabilitation, psychiatric, and children's hospitals, as well as LTCHs and rehabilitation and psychiatric units of acute care hospitals. Therefore, the statute (section 1886(d)(1)(B) of the Act) excluded these classes of hospitals and units from the prospective payment system for short-term acute care hospitals. The excluded hospitals and units continued to receive payments based on costs subject to a cap on each facility's per discharge costs during a base year, with a yearly update as set forth in Public Law 97–248. (Cancer hospitals were added to the list of excluded hospitals by section 6004(a) of Public Law 101–239.)

C. Patient Classifications by DRGs

1. Objectives of the Classification System

The DRGs are a patient classification system that provides a means of relating the type of patients treated by a hospital (that is, its case-mix) to the costs incurred by the hospital. In other words, DRGs relate a hospital's case-mix to the resource intensity experienced by the hospital. That is, a hospital that has a more complex case-mix treats patients who require more hospital resources.

While each patient is unique, groups of patients have demographic, diagnostic, and therapeutic attributes in common that determine their level of resource intensity. Given that the purpose of DRGs is to relate a hospital's case-mix to its resource intensity, it was necessary to develop a way of determining the types of patients treated and to relate each patient type to the resources they consumed. In the development of the existing CMS–DRGs, in order to aggregate patients into meaningful patient classes, it was essential to develop clinically similar groups of patients with similar resource intensity. The characteristics of a practical and meaningful DRG system were distilled into the following objectives:

- The patient characteristics should be limited to information routinely collected on hospital abstract systems.
- There should be a manageable number of DRGs encompassing all patients.
- Each DRG should contain patients with a similar pattern of resource intensity.
- DRGs should be clinically coherent, that is, containing patients who are similar from a clinical perspective.

Under a DRG-based system, patient information routinely collected include the following six data items: principal diagnosis, secondary or additional diagnoses, procedures, age, gender, and discharge status. All hospitals routinely collect this information. Therefore, a classification system based on these elements could be applied uniformly across hospitals.

Limiting the number of DRGs to a manageable total (that is, hundreds of patient classes instead of thousands) ensures that, for most of the DRGs, hospital discharge data would allow for meaningful comparative analysis to be performed. If a hospital has a sufficient number of cases in particular DRGs, this will allow for evaluations and comparisons of resource consumption by patients grouped to those DRGs, as compared to resources consumed by patients grouped to other DRGs. A large number of DRGs with only a few patients in each group would not provide useful patterns of case-mix complexity and cost performance.

The resource intensity of the patients in each DRG must be similar in order to establish a relationship between the case-mix of a hospital and the resources it consumes. (Similar resource intensity means that the resources used are relatively consistent across the patients in each DRG.) In implementing the original DRGs for the acute care hospital inpatient prospective payment system, we recognized that some variation in resource intensity would be present among the patients in each DRG, but the level of variation would be identifiable and predictable.

The last characteristic for an effective patient classification system is that the patients in a DRG are similar from a clinical perspective; that is, the definition of a DRG has to be clinically coherent. This objective requires that the patient characteristics included in the definition of each DRG be related to a common organ system or etiology, and that a specific medical specialty should typically provide care to the patients in a particular DRG.

2. DRGs and Medicare Payments

The LTC–DRGs used as the patient classification component of the LTCH prospective payment system correspond to the DRGs in the acute care hospital inpatient prospective payment system. We modified the CMS–DRGs for the LTCH prospective payment system by developing LTCH-specific relative weights to account for the fact that LTCHs generally treat patients with multiple medical problems. As background to understand our use of LTC–DRGs in the LTCH prospective payment system, we are presenting a brief review of the DRG patient classification system in the acute care hospital inpatient prospective payment system.

Generally, under the prospective payment system for short-term, acute care hospital inpatient services, Medicare payment is made at a predetermined, specific rate for each discharge; that payment varies by the DRG to which a beneficiary's stay is assigned. Cases are classified into DRGs for payment based on the following six data elements:

(1) Principal diagnosis.
(2) Up to eight additional diagnoses.
(3) Up to six procedures performed.
(4) Age.
(5) Sex.

(6) Discharge status of the patient.

Hospitals report the diagnostic and procedure information from the patient's hospital record using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) codes on the uniform billing form currently in use, which is submitted to the Medicare fiscal intermediaries.

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

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

After screening through the MCE and after any further development of the claims, cases are classified into the appropriate DRG by a software program called the GROUPER using the six data elements noted above.

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

The DRGs are organized into 25 Major Diagnostic Categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. While we do not anticipate large numbers of surgical cases in LTCHs, 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. Generally, the GROUPER does not recognize certain other procedures; that is, those procedures not surgical (for example, EKG), or minor surgical procedures generally not performed in an operating room and, therefore, not considered as surgical by the GROUPER (for example, 86.11, Biopsy of skin and subcutaneous tissue).

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

D. LTC–DRG Classification System for LTCHs

Unless otherwise noted, our analysis of a per discharge DRG-based patient classification system is based on LTCH data from the FY 2001 MedPAR file, which contains hospital bills received through May 31, 2001, for hospital discharges occurring in FY 2001.

The patient classification system for the LTCH prospective payment system is based on the acute care hospital inpatient prospective payment system currently used for Medicare beneficiaries. Within the LTCH data set, as identified by provider number, we classified all cases to the CMS–DRGs. For the proposed rule, we identified individual LTCH cases with a length of stay equal to or less than 7 days and grouped them into two very short-stay LTC–DRGs, which we discussed in detail (67 FR 13434 and 13453–13454). However, as discussed later in section X.D. of this preamble, we are not adopting the proposed very short-stay discharge policy in this final rule. Instead, we are revising the short-stay outlier policy to take into account adjustments to payments for cases in which the stay at the LTCH is five-sixths of the geometric average length of stay for LTCHs.

As a result, the patient classification system consists of 510 DRGs that form the basis of the FY 2003 LTCH prospective payment system GROUPER. The 510 LTC–DRGs include two ''error DRGs''. As in the acute care hospital inpatient prospective payment system, we are including two error DRGs in which cases that cannot be assigned to valid DRGs will be grouped. These two error DRGs are DRG 469 (Principal Diagnosis Invalid as a Discharge Diagnosis) and DRG 470 (Ungroupable). (*See* 66 FR 40062, August 1, 2001.) The other 508 LTC–DRGs are the same DRGs used in the acute care hospital inpatient prospective payment system GROUPER for FY 2003 (Version 20.0). Therefore, cases submitted to the fiscal intermediaries will be processed using the data elements, MCE, and the GROUPER system already in place for the acute care hospital inpatient prospective payment system as described above.

Although payments to LTCHs will be made for the 3-month period following the effective date of the LTCH prospective payment system on October 1, 2002 under the existing electronic claims processing procedure, using ICD–9–CM coding, LTCH payments will be reconciled once the claims processing systems are changed to recognize the new LTCH prospective payment system. LTCHs will be paid based on the LTC–DRGs as determined by the ICD–9–CM codes recorded on the patient claims. Therefore, we would urge LTCHs to focus on improved coding practices, which are addressed in section IX.E. of this final rule.

E. ICD–9–CM Coding System

1. Historical Use of ICD–9–CM Codes

The Ninth Revision of the International Classification of Diseases, Clinical Modification, was adapted for use in the United States in 1979. This

coding system is the basis for the CMS–DRGs, upon which the LTC–DRGs are based. The ICD–9–CM codes have historically been used on all hospital inpatient claims submitted to CMS for payment. Volumes 1 and 2 of the ICD–9–CM coding scheme (including the *Official ICD–9–CM Guidelines for Coding and Reporting*) describe diagnoses, including diseases, injuries, impairments, other health problems, their manifestations, and their causes. The ICD–9–CM Volume 3 describes procedures performed on patients (including the *Official ICD–9–CM Guidelines for Coding and Reporting*). These guidelines are available through a number of sources, including the following Web site: *http://www.cdc.gov/nchs/data/icdguide.pdf.*

We note that should the Secretary, in the future, adopt a different medical data code set, hospitals participating in the Medicare program would be required to use that code set.

2. Uniform Hospital Discharge Data Set (UHDDS) Definitions

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

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

- Diagnoses include all diagnoses that affect the current hospital stay.
- Principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

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

As discussed in section VIII.H. of this final rule and consistent with the procedures for review of CMS–DRGs under the acute care hospital inpatient prospective payment system, we are providing LTCHs with a 60-day window after the date of the notice of the initial LTC–DRG assignment to request review of that assignment. Additional information may be provided by the LTCH to the fiscal intermediary as part of that review.

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

In September 1985, the ICD–9–CM Coordination and Maintenance (C&M) Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and CMS, that is charged with maintaining and updating the ICD–9–CM system. The C&M Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The C&M Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

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

The C&M Committee encourages participation by health-related organizations in the above process. In this regard, the committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups, as well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and those comments submitted in writing, the C&M Committee formulates recommendations, which then must be approved by the heads of the respective agencies.

The C&M committee presents proposals for coding changes at two public meetings per year held at the CMS Central Office located in Baltimore, Maryland. The agenda and date of the meeting can be accessed on the CMS Web site at: *http://www.cms.gov/medicare/icd9cm.asp*.

After consideration of public comments received at both meetings and in writing, CMS publishes the coding changes in the annual proposed and final rules in the **Federal Register** on Medicare program changes to the short-term, acute care hospital inpatient prospective payment system. For example, new codes effective for discharges on or after October 1, 2002, can be found in Tables 6A through 6F of the August 1, 2002 hospital inpatient prospective payment system and rates for FY 2003 final rule (67 FR 50239 through 50243).

All changes to the ICD–9–CM coding system affecting DRG assignment are addressed annually in the acute care hospital inpatient prospective payment system proposed and final rules. Since the DRG-based patient classification system for the LTCH prospective payment system is based on the acute care hospital inpatient prospective payment system DRGs, these changes will also affect the LTCH prospective payment system DRG patient classification system. As coding changes may have an impact on DRG assignment, LTCHs will be encouraged to obtain and correctly use the most current edition of the ICD–9–CM codes. The official version of the ICD–9–CM codes is available on CD–ROM from the U.S. Government Printing Office. The FY 2003 version can be ordered by contacting the Superintendent of Documents, U.S. Government Printing

Office, Dept. 50, Washington, DC 20402–9329, telephone: (202) 512–1800. The stock number is not available at this time, but the price is $22.00. This version will go out of date on October 1, 2002. LTCHs can also order the CD–ROM online at *http://www.bookstore.gpo.gov*. In addition, private vendors also publish the ICD–9–CM Codes in book and electronic formats.

Copies of the procedure portion only of the ICD–9–CM Coordination and Maintenance Committee minutes can be obtained from the CMS Web site at: *http://www.cms.gov/medicare/icd9cm.asp*. There is a direct link to NCHS's Web site from this Web site. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, NCHS Room 1100, 6525 Belcrest Road, Hyattsville, MD 20782. Comments may be sent by e-mail to: *dfp4@cdc.gov*.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Purchasing Policy Group, Division of Acute Care, Mail Stop C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by e-mail to: *pbrooks@cms.hhs.gov*.

As noted above, the ICD–9–CM code changes that have been approved would become effective at the beginning of the Federal fiscal year, October 1. Of particular note to LTCHs will be the invalid diagnosis codes (Table 6C) and the invalid procedure codes (Table 6D) located in the annual proposed and final rules of the acute care hospital inpatient prospective payment system. Claims with invalid codes will not be processed by the Medicare claims processing system.

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

The emphasis on the need for proper coding cannot be overstated. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC–DRG and produce inappropriate weighting factors at recalibration.

Although payments to LTCHs will be made for the 3-month period following the effective date of the LTCH prospective payment system on October 1, 2002, using the existing electronic claims processing procedure, LTCH payments will be reconciled once the claims processing systems are changed to recognize the new LTCH prospective payment system. LTCHs will be paid based on the LTC–DRGs as determined by the ICD–9–CM codes recorded on the patient claims. Therefore, we are urging LTCHs to focus on improved coding practices which are addressed in section IX.E. of this final rule.

Because of our concern with correct coding practice, CMS has been working with AHA's Editorial Advisory Board on its publication, *Coding Clinic for ICD–9–CM,* since 1984. The *Coding Clinic* was developed to improve the accuracy and uniformity of medical record coding and is recognized in the industry as the definitive source of coding instruction. In 1987, the AHA created the cooperating parties, who have final approval of the coding advice provided in the *Coding Clinic*. The cooperating parties consist of the AHA, the AHIMA (formerly AMRA), CMS (formerly HCFA), and NCHS. As we participate on the Editorial Advisory Board and are one of the cooperating parties, we support the use of the Coding Clinic for coding advice for LTCHs. Information about the Coding Clinic can be obtained from the American Hospital Association, Central Office on ICD–9–CM, One North Franklin, Chicago, IL 60606, or at its Web site at *http://www.ahacentraloffice.org*.

Based on our review of claims data submitted by LTCHs, we believe it is worthwhile to review some of the basic instructions for coding. Our compelling need is based on the review of the data submitted by LTCHs. We note that the logic of the care patterns or place of treatment should not be considered in reviewing the following scenarios. Rather, these are merely examples to illustrate correct coding practice.

• Principal diagnosis—As noted above, the specific definition for principal diagnosis established by the 1984 Revision of the Uniform Hospital Discharge Data Set is ''the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.'' When a patient is discharged from an acute care facility and admitted to a LTCH, the appropriate principal diagnosis at the LTCH is not necessarily the same diagnosis for which the patient received care at the acute care hospital. For example, a patient who suffers a stroke (code 436, Acute, but ill-defined, cerebrovascular disease) is admitted to an acute care hospital for diagnosis and treatment. The patient is then discharged and admitted to a LTCH for further treatment of left-sided hemiparesis and dysphasia. The appropriate principal diagnosis at the LTCH would be a code from section 438 (Late effects of cerebrovascular disease), such as 438.20 (Late effects of cerebrovascular disease, Hemiplegia affecting unspecified side) or 438.12 (Late effects of cerebrovascular disease, Dysphasia).

Coding guidelines state that the residual condition is sequenced first followed by the cause of the late effect. In the case of cerebrovascular disease, the combination code describes both the residual of the stroke (for example, speech or language deficits or paralysis) and the cause of the residual (the stroke). Code 436 is used only for the first (initial) episode of care for the stroke that was in the acute care setting.

• Other diagnoses—Secondary diagnoses that have no bearing on the LTCH stay are not coded. For example, a patient who has recovered from pneumonia during a previous episode of care will not have a diagnosis code for pneumonia included in his or her list of discharge diagnoses. The pneumonia was not treated during this LTCH admission and, therefore, has no bearing on this case.

• Procedures—Codes reflecting procedures provided during a previous acute care hospital stay are not included because the procedure was not performed during this LTCH admission. For example, a patient with several chronic illnesses is admitted to an acute care hospital with a diagnosis of appendicitis for which he or she receives an appendectomy. The patient subsequently is transferred to a LTCH for medical treatment following surgery, and as a result of the multiple secondary conditions, the patient needs a higher level of care than he or she could receive at home with an HHA. In this situation, appendicitis will not be coded because this condition was resolved with the removal of the appendix. The procedure code for appendectomy will not be used on the LTCH record, as the procedure was performed in the acute care setting, not during the LTCH admission.

We will train fiscal intermediaries and providers on the new system. We also will issue manuals containing procedures as well as coding instructions to LTCHs and fiscal intermediaries following the publication of this final rule.

Comment: One commenter approved of CMS' intent to use ICD–9–CM codes and the *Official Guidelines for Coding and Reporting*, but noted that LTCHs will need clarification regarding which portion of the guidelines applies to them. The commenter specifically mentioned that the scenario presented as an example of selection of a principal diagnosis for a stroke patient (67 FR 13436) specifies ICD–9–CM code 438

(Late effects of cerebrovascular disease) rather than the 436 codes reportable by an acute care hospital, and noted that the LTCH admission should be considered a transfer.

Response: We intend that the *Official Guidelines for Coding and Reporting,* available at *http://www.cdc.gov/nchs/data/icdguide.pdf*, be used for LTCHs in the same manner that they are used by short-term acute care hospitals. The Guidelines state that selection of a principal diagnosis is always governed by the circumstances of the admission (Section 2, Selection of Principal Diagnosis). Further, we also recommend that the American Hospital Association's publication *Coding Clinic for ICD–9–CM* be used to improve the accuracy and uniformity of medical record coding in LTCHs, just as it is used in acute care hospitals.

In the example cited above, we referenced *Coding Clinic Fourth Quarter 1998* (pp. 88 through 89) for advice on coding CVA. Specifically, we stated that codes from categories 430–437 should be used throughout the initial episode of care for an acute cerebral hemorrhage or infarction. When codes from the 430–437 series are used, additional codes are needed to identify any sequelae present (for example, hemiplegia [a code from category 342] and aphasia [784.3]). Once a patient has completed the initial treatment or is discharged from care, codes from category 438 should be assigned instead of codes from the 430–437 series to identify residual neurologic deficits.

When a patient is discharged from a short-term acute care hospital and is admitted to a LTCH, the initial treatment period is over and it is assumed that the patient has maximized the benefits of hospitalization possible for that level of care. When the patient is then admitted to a LTCH, the focus of treatment has shifted from identification and treatment of the acute episode to treatment for the sequelae or residual deficits resulting from the acute process. We further note that, for coding purposes, a transfer from an acute care setting to a LTCH is, as defined at § 412.4(c), a discharge instead of a transfer. (For payment purposes, if the acute care DRG falls into the postacute transfer policy, regulations at § 412.4 govern.)

Therefore, we reiterate that our advice in the coding example cited in the proposed rule was correct. The appropriate principal diagnosis at the LTCH would be a code from section 438 (Late effects of cerebrovascular disease).

Comment: One commenter stated that CMS should ensure that its contractors (fiscal intermediaries) have been thoroughly trained and prepared for the LTCH prospective payment system before it is implemented. This commenter also suggested that fiscal intermediaries should be required to attest to their training and preparation. The commenter further suggested that CMS issue coding and training manuals to LTCHs as far in advance of implementation of the LTCH prospective payment system as possible.

Another commenter noted that current coding guidelines are vague insofar as they pertain to LTCHs, and called for the development of specific coding guidelines relating to the transfer of patients from acute care hospitals so that records will be appropriately coded for the LTCH prospective payment system.

Response: The fiscal intermediaries have been processing claims for acute care hospitals under the acute care hospital inpatient prospective payment system since its inception in 1983. We are confident that, given almost two decades of experience, they are prepared for, and capable of, processing LTCH claims for LTC–DRGs as well. However, the fiscal intermediaries will be receiving instruction and an overview of the new system before its implementation on October 1, 2002. The LTCH prospective payment system so closely mimics the acute care hospital inpatient prospective payment system that we have no overriding concerns about the fiscal intermediaries' capabilities. We do not believe an attestation by the fiscal intermediaries is necessary, and will monitor their performance as with the implementation of any new payment system.

The training that is to be provided by the fiscal intermediaries will be coordinated through CMS' Division of Provider Education and Training. That schedule has not yet been established, but information will be forthcoming to member hospitals from their fiscal intermediaries at a later date. This training will be given as soon as possible before the implementation of the LTCH prospective payment system.

With regard to coding issues, both the LTCHs and the short-term acute care hospitals should be applying the coding rules in the same manner. Since the inception of the acute care hospital inpatient prospective payment system, we have recommended that providers adopt and use the *ICD–9–CM Guidelines for Coding and Reporting* and the reporting definitions as set forth in the Uniform Hospital Discharge Data Set (UHDDS). We stated this recommendation in the proposed rule (67 FR 13435), and it was also discussed in the Standards for Electronic Transactions (65 FR 50312). In the proposed rule, we also expressed our concern for correct coding practice (67 FR 13436), and suggest that providers use the American Hospital Association's publication Coding Clinic for ICD–9–CM to improve the accuracy and uniformity of medical record coding and reporting. We take this opportunity to reiterate that we are one of the four cooperating parties on AHA's Editorial Advisory Board for *Coding Clinic*, and we support the use of *Coding Clinic* for coding advice for LTCHs.

The LTCHs will be using the same guidelines as the short-term, acute care hospitals. We anticipate that when coding questions arise, the AHA will manage them in the same manner for both types of facilities. That is, coding questions submitted to the AHA will be brought before their Editorial Advisory Board for consideration and resolution. Answers to questions will either be published in *Coding Clinic* or will be answered directly. Information concerning *Coding Clinic* should be obtained from the American Hospital Association, Central Office on ICD–9–CM, One North Franklin, Chicago, IL 60606, or at its Web site at *http://www.ahacentraloffice.org.*

With regard to the comment that development of specific coding guidelines be developed that take into account the ''transfer'' of patients from acute care hospitals to LTCHs, we again state that when a patient is discharged from a short-term, acute care hospital and is admitted to a LTCH, the initial treatment period is over. Subsequent admission to a LTCH would require that the reason for the admission be examined and the principal diagnosis determined based on the merits of that admission.

Comment: Two commenters expressed concern that CMS had inaccurately determined the volume and subsequent relative weights for two LTC–DRGs. Those LTC–DRGs are DRG 475 (Respiratory System Diagnosis with Ventilator Support) and DRG 87 (Pulmonary Edema and Respiratory Failure). Patients grouped to DRG 475 were given a proposed relative weight of 2.3043, while patients grouped to DRG 87, who are patients not requiring ventilator support, were given a higher proposed weight of 2.4202. The commenter believed that when providers submitted multiple interim bills, the procedure code reflecting ventilator use was not reported on each interim bill, resulting in an inaccurate number of cases in each of the two DRGs and ultimately resulting in an

inaccurate computation of the relative weights for both DRGs.

Response: While the relative weights of 475 and 87 are not a coding issue, the hospital's method of reporting the codes has impacted DRG assignments and relative weights. The impact of how codes are reported is an issue that we did not anticipate when we computed the original relative weights. When providers submit multiple interim bills to us, only the diagnostic and procedural code data contained on the most recent bill are extracted for the MedPAR data file. When the DRG relative weights for the proposed rule were computed, they were based on the most recent MedPAR data. However, this data set contained some cases that apparently did not include all the codes that would have been present on the first billing. In one of the most striking examples, in those situations when the procedure code for ventilator use was not included on the bill, the DRG shifted from 475 to 87. As a result of this finding, we have reviewed the MedPAR file and recalibrated the relative weights based on the first data submitted to MedPAR. Relative weights in Table 3 in the Addendum to this final rule reflect our revised calculations.

Relative to correct coding practice for hospitals submitting interim bills, we have consulted with the members of the four Cooperating Parties (as discussed in section VIII.E.4. of this preamble) and have determined that correct coding practice includes the following concepts:

- The principal diagnosis will remain the same throughout the entire LTCH stay, and will be reported as the principal diagnosis on each claim submitted.
- Secondary or additional diagnoses will be coded as these conditions develop and will be reported on each claim submitted. For example, a LTCH patient develops a condition, such as decubiti, that was not present on admission. The code for this condition should be added to the next claim submitted, and will continue to be coded, even if the decubiti are successfully treated and ultimately resolved before the patient's discharge from the LTCH. If all appropriate secondary diagnoses, up to eight, are not present on the final claim, the DRG may not be correctly assigned. It is the responsibility of the LTCH to make sure their coding practices reflect proper coding on their claims.
- All procedures performed in the LTCH will be reported. This means that if a patient is on a ventilator at the beginning of his or her LTCH stay, or is placed on a ventilator during that stay, but is subsequently weaned from the ventilator, the ventilator code will continue to appear on all claims. This is true for the duration of that LTCH stay. Likewise, if a patient has another type of procedure such as 54.51 (Laparoscopic lysis of peritoneal adhesions), code 54.51 should continue to be reported on each claim submitted for the duration of the patient's stay at the LTCH.

The above guidelines are in place for short-term, acute care hospitals and assure accurate and consistent coding practice. LTCHs are to follow the coding guidelines for the acute care hospitals to ensure that same accuracy and consistency. There will be only one DRG assigned per long-term care hospitalization; it will be assigned at the discharge. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnostic codes that coexist at the time of admission, that subsequently develop, or that affect the treatment received. Similarly, all procedures performed during that stay are to be reported on each claim.

X. Payment System for LTCHs

In accordance with section 123(a)(1) of Public Law 106–113, we are using a discharge as the payment unit for the LTCH prospective payment system for Medicare patients. We will update the per discharge payment amounts annually. The payment rates encompass both inpatient operating and capital-related costs of furnishing covered inpatient LTCH services, including routine and ancillary costs, but not the costs of bad debts, approved educational activities, blood clotting factors, anesthesia services furnished by hospital-employed nonphysician anesthetists or obtained under arrangement, or the costs of photocopying and mailing medical records requested by a QIO, which are costs paid outside the prospective payment system. Generally, consistent with current policy under § 412.42, beneficiaries may be charged only for deductibles, coinsurance, and noncovered services (for example, telephone and television). In addition, beneficiaries may be charged for services furnished during a LTCH stay that are not covered under Medicare. They may not be charged for the differences between the hospital's cost of providing covered care and the Medicare LTCH prospective payment amount for the full LTC–DRG. (For further details, see section VIII.C. of this preamble.)

We determine the LTCH prospective payment rates using relative weights to account for the variation in resource use among LTC–DRGs. During FY 2003, the LTCH prospective payment system will be ''budget neutral'' in accordance with section 123(a)(1) of Public Law 106–113. That is, total payments for LTCHs during FY 2003 will be projected to equal payments that would have been paid for operating and capital-related costs of LTCHs had this new payment system not been enacted. Budget neutrality is discussed in detail in section X.J.2.h. of this preamble.

Based on our analysis of the data, we will make additional payments to LTCHs for discharges meeting specified criteria as high-cost ''outliers.'' Outliers are cases that have unusually high costs, exceeding the LTC–DRG payment plus the fixed loss amount, as discussed in section X.J.6. of this preamble. In addition to a high-cost outlier policy, we also are implementing payment policies regarding short-stay outliers and interrupted stays (sections X.C. and X.E. of this preamble).

In general, we are adopting the provisions for determining the prospective payments under the LTCH prospective payment system that we included in our March 22, 2002 proposed rule. If changes in this final rule have been made as a result of comments received, we discuss those changes in the context of the policy areas specified in this section of the preamble.

The LTCH prospective payment system uses Federal prospective payment rates across 499 distinct LTC–DRGs. We have established a standard Federal payment rate based on the best available LTCH cost data. LTC–DRG relative weights are applied to the standard Federal rate to account for the relative differences in resource use across the LTC–DRGs. As finalized in this final rule, the system also includes adjustments for short-stay outliers, differences in area wages (transitioned over 5 years), COLAs in Alaska and Hawaii, and high-cost outlier cases, as described in sections X.D., X.J.1., X.J.5., and X.J.6. of this preamble, respectively.

The standard Federal prospective payment rate, which is the basis for determining Federal payment rates for each LTC–DRG, is determined based on average costs from a base period, and also reflects the combined aggregate effects of the payment weights and other policies discussed in this section. In discussing the methodology, we begin by describing the various adjustments and factors that were considered in establishing the standard Federal prospective payment rate. We developed prospective payments for LTCHs using the following major steps:

- Develop the LTC–DRG relative weights.
- Determine appropriate payment system adjustments.
- Calculate the budget neutral standard Federal prospective payment rate.
- Calculate the Federal LTC–DRG prospective payments.

A detailed description of each step and a discussion of our policies for special cases, payment adjustments, phase-in implementation, and other policies follow.

A. Development of the LTC–DRG Relative Weights

1. Overview of Development of the LTC–DRG Relative Weights

As previously stated, one of the primary goals for the implementation of the LTCH prospective payment system is to pay each LTCH an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we adjust the standard Federal prospective payment system rate by the LTC–DRG relative weights in determining payment to LTCHs for each case.

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

To calculate the relative weights in the proposed rule, we obtained charges from FY 2000 Medicare hospital bill data from the June 2001 update of the MedPAR file, and we used Version 18.0 of the CMS GROUPER (used under the acute care hospital inpatient prospective payment system for FY 2001). In this final rule, we recalculated the relative weights based on the most recent MedPAR data (that is, the March 2002 update of the FY 2001 Medicare hospital bill data, which include bills submitted through March 31, 2002) and Version 20.0 of the CMS GROUPER (used under the acute care hospital inpatient prospective payment system for FY 2003). As we stated in the proposed rule, we have recalculated the LTC–DRG relative weights based on the most recent available data in this final rule. At the time the proposed rule was published, we anticipated that Version 19 of the CMS GROUPER (used under the hospital inpatient prospective payment system for FY 2002) would be the most recently available. However, due to the recent publication of the FY 2003 acute care hospital inpatient prospective payment system final rule, we were able to use the Version 20 of the CMS GROUPER.

As we discuss in further detail in section X.K.2.a. of this preamble, based on comments regarding the data used in the development of the proposed LTCH prospective payment system, we have reconsidered the appropriateness of including data from LTCHs that are all-inclusive rate providers (AIRPs) and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1).

Since all-inclusive rate providers have no charge structure, it is not feasible to use charge data for these LTCHs to accurately project variations in Medicare patient resource use. We do not believe their charges are at all comparable to the data for other LTCHs and, therefore, believe that including data from AIRPs would have the potential to inappropriately skew relative weight determinations. As a result, in order to eliminate the influence that including AIRPs would have on the LTC–DRG relative weights, we have excluded the data of the 17 AIRPs in the calculation of the final LTC–DRG relative weights. Excluding the AIRPs' data is consistent with the methodology used in establishing the IRF prospective payment system (66 FR 41351, August 7, 2001). In addition, LTCHs that are reimbursed in accordance with demonstration projects are not subject to the LTCH prospective payment system. Therefore, we determined it would not be appropriate to include their data in the development of the LTC–DRG relative weights, and we have excluded the data from these three LTCHs in calculating the final LTC–DRG relative weights.

Comment: One commenter inquired whether data on ''charges'' and ''length of stay'' from the MedPAR cases used to determine the proposed LTC–DRG relative weights were covered charges and covered days, rather than total charges and total days.

Response: For the proposed rule, we used covered charges and covered days in the determination of the proposed LTC–DRG relative weights. However, in this final rule, we have reevaluated this decision and determined that consistent with our use of total days in the LTCH length of stay qualification formula (section VIII.B.2. of this preamble), it is appropriate to use total days and total charges in the calculation of the LTC–DRG relative weights. As we explain in section VIII.B.2. of this final rule, in our determination of whether a hospital qualifies for payment under the LTCH prospective payment system, total patient days, rather than covered days, will be used in computing a LTCH's required average length of stay of greater than 25 days for Medicare patients. We are adopting this policy because we believe that a criterion based on the total number of treatment days for Medicare patients is a better indication of the appropriateness of the patient's stay at a LTCH than the number of days covered by Medicare for payment purposes.

In the same way that counting total days better reflects whether or not the patient was appropriately hospitalized at a LTCH, charges for the entire length of stay (for example, charges for both the covered and noncovered days of the stay) will more accurately reflect the clinical resources expended in providing care for a specific diagnosis than will charges based only on Medicare-covered days. We believe that the number of covered days for individual Medicare patients treated in LTCHs may not be a reliable source of clinical information for determining and recalibrating the LTC–DRG relative weights. For example, a patient with a diagnosis of a pulmonary embolism would be grouped to LTC–DRG 78, which has an average length of stay of 20.5 days. If that patient only had 2 days of Medicare coverage remaining such that only those 2 covered days and charges were included in determining the LTC–DRG relative weights, those numbers would not represent the actual clinical services required to treat a patient in that LTC–DRG. Therefore, we have revised our methodology and have calculated the final LTC–DRG relative weights using total charges and total days. Using total charges and total lengths of stay enables us to more accurately measure the resources expended in treating a particular LTC–DRG as compared to other LTC–DRGs. This will allow us to establish a clinically driven determination of relative weights (unaffected by a patient's number of covered days of

care) and, therefore, will result in more appropriate payments.

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such nonarbitrary distribution of cases with relatively high (or low) charges in specific LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, as we stated in the proposed rule, we use a hospital-specific relative value method to calculate relative weights. We believe this method will remove this hospital-specific source of bias in measuring average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge. As MedPAC noted in its June 2000 Report to Congress, the hospital-specific relative value method eliminates distortion in the weights due to systematic differences among hospitals in the level of charge markups or costs (p. 58). The case-mix index is the average case weight (adjusted to eliminate the effect of short-stay outliers that are described in section X.C. of this preamble) for cases at each LTCH.

As we explained in the proposed rule (67 FR 13437), under the hospital-specific relative value method, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, averages 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

We standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers as described in section X.C. of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated. The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

As we explained in the proposed rule, multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight in a hospital with higher average costs than they would at a LTCH with low average costs which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case in a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case in a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

In order to account for LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), as we discussed in the proposed rule (67 FR 13438), we group those low volume LTC–DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For this final rule, using LTCH cases from the March 2002 update of the FY 2001 MedPAR file, we identified 161 LTC–DRGs that contained between 1 and 24 cases. This list of LTC–DRGs was then divided into one of the five low volume quintiles, each containing a minimum of 32 LTC–DRGs (161/5 = 32 with 1 LTC–DRG as a remainder). We made an assignment to a specific quintile by sorting the 161 low volume DRGs in ascending order by average charge. Since the number of LTC–DRGs with less than 25 LTCH cases is not evenly divisible by five, the average charge of the low volume LTC–DRG was used to determine which quintile received the additional LTC–DRG. After sorting the 161 volume LTC–DRGs in ascending order, the first fifth of low volume (32) LTC–DRGs with the lowest average charge are grouped into Quintile 1. This process was repeated through the remaining low volume LTC–DRGs so that 4 quintiles contained 32 LTC–DRGs and 1 quintile contained 33 LTC–DRGs. Since the average charge of the 97th LTC–DRG in the sorted list is closer to the previous LTC–DRG's average charge (assigned to Quintile 3) than to the average charge of the 98th LTC–DRG on the sorted list (to be assigned to Quintile 4), it is placed into Quintile 3. The highest average charge cases are grouped into Quintile 5. In order to determine the relative weights for the LTC–DRGs with low volume, we used the five low volume quintiles described above. The composition of each of the five low volume quintiles shown below in Chart 2 are used in determining the final LTC–DRG relative weights for FY 2003. We determine a relative weight and average length of stay for each of the five low volume quintiles using the formula applied to the regular LTC–DRGs (25 or more cases), as described in section X.A.2. of this final rule. We assign the same relative weight and average length of stay to each of the LTC–DRGs that make up that low volume quintile. We note that as this system is dynamic, it is entirely possible that the number and specific type of LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low volume LTC–DRGs and to calculate the relative weights based on our methodology.

CHART 2.—COMPOSITION OF LOW VOLUME QUINTILES

LTC–DRG	Description
	Quintile 1
021	VIRAL MENINGITIS
045	NEUROLOGICAL EYE DISORDERS
047	OTHER DISORDERS OF THE EYE AGE >17 W/O CC
066	EPISTAXIS
067	EPIGLOTTITIS
072	NASAL TRAUMA & DEFORMITY
084	MAJOR CHEST TRAUMA W/O CC
095	PNEUMOTHORAX W/O CC
118	CARDIAC PACEMAKER DEVICE REPLACEMENT
150	PERITONEAL ADHESIOLYSIS W CC
157	ANAL & STOMAL PROCEDURES W CC
208	DISORDERS OF THE BILIARY TRACT W/O CC
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY
284	MINOR SKIN DISORDERS W/O CC
290	THYROID PROCEDURES
301	ENDOCRINE DISORDERS W/O CC
307	PROSTATECTOMY W/O CC
311	TRANSURETHRAL PROCEDURES W/O CC
329	URETHRAL STRICTURE AGE >17 W/O CC
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17
348	BENIGN PROSTATIC HYPERTROPHY W CC
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC
360	VAGINA, CERVIX & VULVA PROCEDURES
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC
	Quintile 2
017	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
022	HYPERTENSIVE ENCEPHALOPATHY
031	CONCUSSION AGE >17 W CC
044	ACUTE MAJOR EYE INFECTIONS
046	OTHER DISORDERS OF THE EYE AGE >17 W CC
055	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES
068**	OTITIS MEDIA & URI AGE >17 W CC
108	OTHER CARDIOTHORACIC PROCEDURES
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC
178	UNCOMPLICATED PEPTIC ULCER W/O CC
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC
273	MAJOR SKIN DISORDERS W/O CC
276	NON-MALIGANT BREAST DISORDERS
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY
324	URINARY STONES W/O CC
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC
341	PENIS PROCEDURES
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS
427	NEUROSES EXCEPT DEPRESSIVE
432	OTHER MENTAL DISORDER DIAGNOSES
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC
447	ALLERGIC REACTIONS AGE >17
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC
467	OTHER FACTORS INFLUENCING HEALTH STATUS
479	OTHER VASCULAR PROCEDURES W/O CC
520	CERVICAL SPINAL FUSION W/O CC
	Quintile 3
043	HYPHEMA

CHART 2.—COMPOSITION OF LOW VOLUME QUINTILES—Continued

LTC–DRG	Description
068*	OTITIS MEDIA & URI AGE >17 W CC
069	OTITIS MEDIA & URI AGE >17 W/O CC
116	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG
168	MOUTH PROCEDURES W CC
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC
177	UNCOMPLICATED PEPTIC ULCER W CC
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC
227	SOFT TISSUE PROCEDURES W/O CC
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC
275***	MALIGNANT BREAST DISORDERS W/O CC
295	DIABETES AGE 0–35
299	INBORN ERRORS OF METABOLISM
306	PROSTATECTOMY W CC
308	MINOR BLADDER PROCEDURES W CC
336	TRANSURETHRAL PROSTATECTOMY W CC
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC
498	SPINAL FUSION W/O CC
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA
519	CERVICAL SPINAL FUSION W CC
	Quintile 4
004	SPINAL PROCEDURES
005	EXTRACRANIAL VASCULAR PROCEDURES
008	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
146	RECTAL RESECTION W CC
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC
225	FOOT PROCEDURES
226	SOFT TISSUE PROCEDURES W CC
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC
310	TRANSURETHRAL PROCEDURES W CC
317	ADMIT FOR RENAL DIALYSIS
342	CIRCUMCISION AGE >17
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM
389	FULL TERM NEONATE W MAJOR PROBLEMS
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC
414***	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC
421	VIRAL ILLNESS AGE >17
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL
505	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI
	Quintile 5
001	CRANIOTOMY AGE >17 W CC

CHART 2.—COMPOSITION OF LOW VOLUME QUINTILES—Continued

LTC–DRG	Description
002	CRANIOTOMY AGE >17 W/O CC
061	MYRINGOTOMY W TUBE INSERTION AGE >17
063	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES
075	MAJOR CHEST PROCEDURES
077	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC
110	MAJOR CARDIOVASCULAR PROCEDURES W CC
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC
115	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY
231	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR
288	O.R. PROCEDURES FOR OBESITY
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM
312	URETHRAL PROCEDURES, AGE >17 W CC
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS
488	HIV W EXTENSIVE O.R. PROCEDURE
497	SPINAL FUSION W CC
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC
501	KNEE PROCEDURES W PDX OF INFECTION W CC
503	KNEE PROCEDURES W/O PDX OF INFECTION
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA
517	PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI

* One of the original 161 low volume LTC–DRGs initially assigned to a different low volume quintile; reassigned to this low volume quintile in addressing nonmonotonicity (see step 4 below).

** One of the original 161 low volume LTC–DRGs initially assigned to this low volume quintile; reassigned to a different low volume quintile in addressing nonmonotonicity (see step 4 below).

*** One of the original 161 low volume LTC–DRGs initially assigned to this low volume quintile; removed from the low volume quintiles in addressing nonmonotonicity (see step 4 below).

After grouping the cases in the appropriate LTC–DRG, we calculate the relative weights in this final rule by first removing statistical outliers and cases with a length of stay of 7 days or less. Next we adjust the number of cases in each LTC–DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges are used to calculate ''relative adjusted weights'' in each LTC–DRG using the hospital-specific relative value method described above. We describe each of these steps in greater detail in section X.A.2. of this preamble.

Comment: Two commenters notified us of a data problem regarding the proposed LTC–DRG relative weight values that were determined using MedPAR (claims) data for FYs 2000 and 2001. The commenters were concerned that two high-volume and high-resource use LTC–DRGs were incorrectly weighted and that this error would not only result in inaccurate payments for certain LTCHs, but also would have negative implications for the accuracy of the overall payment system.

Response: Following notification of this problem, we researched the commenter's claims and determined that, given the long stays at LTCHs, some providers had submitted multiple bills for payment under the TEFRA reimbursement system for the same stay. In establishing the LTC–DRG relative weights in the proposed rule, these claims from the MedPAR file were run through the LTCH GROUPER and used in determining the proposed relative weights for each LTC–DRG. Based upon our research, we became aware of the following situation: in certain LTCHs, hospital personnel apparently reported a different principal diagnosis on each bill since, under the TEFRA system, payment was not dependent upon principal diagnosis as it is under a DRG-based system. Moreover, since we discovered that only data from the final bills were being extracted for the MedPAR file, it is possible that the original MedPAR file would not be receiving the correct principal diagnosis. In this final rule, we have addressed the problem by identifying all LTCH cases in the MedPAR file for which multiple bills were submitted. For each of these cases, beginning with the first bill and moving forward consecutively through subsequent bills for that stay, we recorded the first unique diagnosis codes up to 10 and the first unique procedure codes up to 10. We then used these codes to group each case to a LTC–DRG. Using this methodology, we note in this final rule that there are significant changes in the relative weights for several LTC–DRGs and consequential changes to the relative weights for the other LTC–DRGs. We recognize the impact that this information had on the accuracy and integrity of the LTCH prospective payment system and appreciate the commenters who brought this issue to our attention and allowed us to address it.

2. Steps for Calculating the Relative Weights

In the March 22, 2002 proposed rule (67 FR 13441–13445), we described the steps for calculating the proposed relative weights for the proposed LTC–DRGs under the proposed LTCH prospective payment system. Proposed Step 1 was ''Adjust charges for the effects of short-stay outliers'' and proposed Step 2 was ''Remove statistical outliers.'' As we have stated in Question 5.8 of the ''Frequently Asked Questions'' posted on the CMS website, the stated order of proposed Step 1 and proposed Step 2 was inadvertently reversed in the proposed rule. In fact, statistical outliers were removed *before* short-stay outliers were adjusted. These steps are shown in the correct order in the description given below for calculating the final relative weights. In addition, in this final rule, we are adding a new step as a result of our elimination of the proposed very short-stay discharge policy discussed in sections X.C. and X.D. of this preamble.

Step 1—Remove statistical outliers.

The first step in the calculation of the relative weights is to remove statistical outlier cases. As we stated in the proposed rule, we define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each LTC–DRG. These statistical outliers are removed prior to calculating the relative weights. We believe that they may represent aberrations in the data that distort the measure of average resource use. Including those cases in the calculation of the relative weights could result in an inaccurate weight that does not truly reflect relative resource use among the LTC–DRGs. Thus, removing statistical outliers results in more appropriate LTC–DRG relative weights and payments.

Step 2—Remove cases with a length of stay of 7 days or less.

In the proposed calculation of the LTC–DRG relative weights, we did not include cases with a length of stay of 7 days or less since we had proposed to assign those cases to one of two very short-stay discharge LTC–DRGs (section X.C. of this preamble). Thus, in the proposed rule, the costs of cases with stays of 7 days or less were factored into those very short-stay discharge LTC–DRG relative weights. As we discuss in further detail in sections X.C. and X.D. of this preamble, even though in this final rule we are now including cases with a length of stay of 7 days or less under the short-stay outlier policy (§ 412.529), we continue to believe that, generally, cases with a length of stay 7 days or less do not belong in a LTCH. Because these cases do not use the same amount or type of resources as typical inlier cases, our simulations have indicated that including these cases in the calculations of the LTC–DRG relative weights would significantly bias payments against inlier cases. (For purposes of payment under the LTCH prospective payment system, an ''inlier case'' means a stay in which Medicare-covered days exceed five-sixths of the geometric average length of stay for a particular LTC–DRG, and the estimated costs for a particular LTC–DRG, and the estimated costs for a particular discharge do not exceed the high-cost outlier threshold (that is, the adjusted LTCH prospective payment system payment for a particular LTC–DRG plus a fixed-loss amount).) The LTC–DRG relative weights should reflect the average of resources used on representative cases of a specific type. Therefore, we continue to believe that cases with stays of 7 days or less should not be included in the calculation of the relative weights.

Stays of 7 days or less generally do not fully receive or benefit from treatment that is typical in a LTCH stay and full resources are often not used in the earlier stages of admission to a LTCH. If we did include stays of 7 days or less in the computation of the LTC–DRG relative weights, the value of many weights would decrease and, therefore, inlier payments would decrease to a level that may no longer be appropriate. We do not believe that it is appropriate to compromise the integrity of the payment determination for those LTCH inlier cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include data from these very short-stays. Thus, in determining the final LTC–DRG relative weights, we have removed cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of short-stay outliers.

The third step in the calculation of the relative weights is to adjust each LTCH's charges per discharge for short-stay outlier cases (that is, a patient with

a length of stay that is less than or equal to five-sixths the average length of stay of the LTC–DRG as described in section X.C. of this final rule).

We make this adjustment by counting a short-stay outlier as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the LTC–DRG for nonshort-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the LTC–DRG. This process produces the same result as if the actual charges per discharge of a short-stay outlier case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the LTC–DRG.

As we stated in the proposed rule, counting short-stay outlier cases as full discharges with no adjustment in determining the relative weights would lower the relative weight for affected LTC–DRGs because the relatively lower charges of the short-stay outlier cases bring down the average charge for all cases within a LTC–DRG. This would result in an ''underpayment'' to nonshort-stay outlier cases and an ''overpayment'' to short-stay outlier cases. Therefore, in this final rule, we are adjusting for short-stay outlier cases in this manner since it will result in more appropriate payments for all LTCH cases. The result of step 3 is that each LTCH's average cost per discharge is adjusted for short-stay outliers (as described above) before calculating the LTC–DRG relative weights on an iterative basis (step 4) using the hospital-specific relative value method.

Step 4—Calculate the LTC–DRG relative weights on an iterative basis.

As explained in the proposed rule, the process of calculating the LTC–DRG relative weights is iterative. First, for each case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier adjusted charge per discharge (see step 3) of the case (after removing the statistical outliers (see step 1)) and cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each LTC–DRG, the LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of LTC–DRG relative weights across all LTCHs. In this final rule, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Adjust the LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As explained in section IX.D. of this preamble, the LTC–DRGs contain ''pairs'' that are differentiated based on the presence or absence of CCs. LTC–DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. The value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a LTC–DRG means that cases classified into a ''without CC'' LTC–DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across ''with CC''/''without CC'' pairs of LTC–DRGs. For a case to be assigned to a LTC–DRG with CCs, more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a LTC–DRG without CCs (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the database includes both accurately coded cases without complications and cases that have complications (and cost more) but were not coded completely. Both types of cases are grouped to a LTC–DRG ''without CCs'' since only one principal diagnosis was coded. Since LTCHs are currently paid under cost-based reimbursement, which is not based on patient diagnoses, LTCHs' coding for these cases may not have been as detailed as possible.

Thus, as we explained in the proposed rule, in developing the relative weights for the LTCH prospective payment system, we found on occasion that the data suggested that cases classified to the LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair had a lower average charge than the corresponding LTC–DRG ''without CCs.'' We believe this anomaly may be due to coding that may not have fully reflected all comorbidities that were present. Specifically, LTCHs may have failed to code relevant secondary diagnoses, which resulted in cases that actually had CCs being classified into a ''without CC'' LTC–DRG. It is not appropriate to pay a lower amount for the ''with CC'' LTC–DRG. Therefore, in this final rule, we continue to group both the cases ''with CCs'' and ''without CCs'' together for the purpose of calculating the relative weights for the LTC–DRGs until we have adequate data to calculate appropriate separate weights for these anomalous LTC–DRG pairs. We expect that, as was the case when we first implemented the acute care hospital inpatient prospective payment system, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

For this final rule, using the LTCH cases in the March 2002 update of the FY 2001 MedPAR file, we identified three types of ''with CC'' and ''without CC'' pairs of LTC–DRGs that are nonmonotonic, that is, where the ''without CC'' LTC–DRG would have a higher average charge than the ''with CC'' LTC–DRG.

The first category of nonmonotonically increasing relative weights for LTC–DRG pairs ''with and without CCs'' contains 1 pair of LTC–DRGs in which both the LTC–DRG ''with CCs'' and the LTC–DRG ''without CCs'' had 25 or more LTCH cases and, therefore, did not fall into one of the 5 quintiles. For that pair of LTC–DRGs, we combine the cases and compute a new relative weight based on the case-weighted average of the combined cases of the LTC–DRGs. The case-weighted average charge is determined by dividing the total charges for all cases by the total number of cases for the combined LTC–DRG. This new relative weight is assigned to both of the LTC–DRGs in the pair. For the FY 2003 implementation of the LTCH prospective payment system in this final rule, LTC–DRGs 10 and 11 are in this category.

The second category of nonmonotonically increasing relative weights for LTC–DRG pairs with and without CCs consists of 1 pair of LTC–DRGs that has fewer than 25 cases and are both grouped to different quintiles in which the ''without CC'' LTC–DRG is in a higher-weighted quintile than the

''with CC'' LTC–DRG. For that pair, we combine the cases and determine the case-weighted average charge for all cases. The case-weighted average charge is determined by dividing the total charges for all cases by the total number of cases for the combined LTC–DRG. Based on the case-weighted average charge, we determined which quintile the ''combined LTC–DRG'' is grouped. Both LTC–DRGs in the pair are then grouped into the same quintile, and thus have the same relative weight. For the FY 2003 implementation of the LTCH prospective payment system in this final rule, LTC–DRGs 68 and 69 (low volume quintile 3) are in this category.

The third category of nonmonotonically increasing relative weights for LTC–DRG pairs with and without CCs consists of 2 pairs of LTC–DRGs where one of the LTC–DRGs has fewer than 25 LTCH cases and is grouped to a quintile and the other LTC–DRG has 25 or more LTCH cases and has its own LTC–DRG weight, and the LTC–DRG ''without CCs'' has the higher weight. We remove the low volume LTC–DRG from the quintile and combine it with the other LTC–DRG for the computation of a new relative weight for each of these LTC–DRGs. This new relative weight is assigned to both LTC–DRGs, so they each have the same relative weight. For the FY 2003 implementation of the LTCH prospective payment system, the following LTC–DRGs are in this category: LTC–DRGs 274 and 275, and LTC–DRGs 413 and 414.

In addition, for the FY 2003 implementation of the LTCH prospective payment system, we determine the relative weight for each LTC–DRG using charges reported in the March 2002 update of the FY 2001 MedPAR file. Of the 510 LTC–DRGs in the CMS LTCH prospective payment system, we identified 159 LTC–DRGs for which there were no LTCH cases in the database. That is, based on the FY 2001 MedPAR file used in this final rule, no patients who would have been classified to those DRGs were treated in LTCHs during FY 2001 and, therefore, no charge data were reported for those DRGs. Thus, in the process of determining the relative weights of LTC–DRGs, we were unable to determine weights for these 159 LTC–DRGs using the method described above. However, since patients with a number of the diagnoses under these LTC–DRGs may be treated at LTCHs beginning in FY 2003, when the LTCH prospective payment system is implemented, we are assigning relative weights to each of the 159 ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 351 (510 − 159 = 351) LTC–DRGs for which we are able to determine relative weights, based on FY 2001 charge data.

As there are currently no LTCH cases in these ''no volume'' LTC–DRGs, we establish relative weights for the 165 LTC–DRGs with no LTCH cases in the FY 2001 MedPAR file used in this final rule by grouping them to the appropriate low volume quintile. This methodology is consistent with our methodology used in determining relative weights to account for low volume LTC–DRGs described above.

As we described in the proposed rule, our methodology for determining relative weights for the ''no volume'' LTC–DRGs is as follows: First, we cross-walk the no volume LTC–DRGs by matching them to other similar LTC–DRGs for which there were LTCH cases in the FY 2001 MedPAR file based on clinical similarity and intensity of use of resources as determined by care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, post-operative care, and length of stay. We assign the weight for the applicable quintile to the no volume LTC–DRG if the LTC–DRG to which it would be cross-walked was grouped to one of the low volume quintiles. If the LTC–DRG to which the no volume LTC–DRG would be cross-walked was not one of the LTC–DRGs grouped to one of the low volume quintiles, we compare the weight of the LTC–DRG to which the no volume LTC–DRG would be cross-walked to the weights of each of the five quintiles and assign the no volume LTC–DRG the relative weight of the quintile with the closest weight. For this final rule, a list of the no volume LTC–DRGs and the LTC–DRG to which it would be crosswalked in order to determine the appropriate low volume quintile for the assignment of a relative weight is shown below in Chart 3.

CHART 3.—NO VOLUME LTC–DRG CROSSWALK AND QUINTILE ASSIGNMENT [1]

LTC–DRG	Description	Cross-walked LTC–DRG	Low volume quintile assigned
3	CRANIOTOMY AGE 0–17	1	Quintile 5
6	CARPAL TUNNEL RELEASE	224	Quintile 1
26	SEIZURE & HEADACHE AGE 0–17	25	Quintile 1
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	29	Quintile 3
32	CONCUSSION AGE >17 W/O CC	25	Quintile 1
33	CONCUSSION AGE 0–17	25	Quintile 1
36	RETINAL PROCEDURES	47	Quintile 1
37	ORBITAL PROCEDURES	47	Quintile 1
38	PRIMARY IRIS PROCEDURES	47	Quintile 1
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	47	Quintile 1
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	47	Quintile 1
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	47	Quintile 1
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	47	Quintile 1
48	OTHER DISORDERS OF THE EYE AGE 0–17	47	Quintile 1
49	MAJOR HEAD & NECK PROCEDURES	63	Quintile 5
50	SIALOADENECTOMY	55	Quintile 2
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	55	Quintile 2
52	CLEFT LIP & PALATE REPAIR	55	Quintile 2
53	SINUS & MASTOID PROCEDURES AGE >17	55	Quintile 2
54	SINUS & MASTOID PROCEDURES AGE 0–17	55	Quintile 2
56	RHINOPLASTY	55	Quintile 2
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	55	Quintile 2
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	55	Quintile 2
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	55	Quintile 2
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	55	Quintile 2
62	MYRINGOTOMY W TUBE INSERTION AGE 0–17	55	Quintile 2
70	OTITIS MEDIA & URI AGE 0–17	67	Quintile 1
71	LARYNGOTRACHEITIS	67	Quintile 1
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	67	Quintile 1
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	67	Quintile 1
91	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	90	Quintile 3
98	BRONCHITIS & ASTHMA AGE 0–17	97	Quintile 1
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 5
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 5
106	CORONARY BYPASS W PTCA	110	Quintile 5
107	CORONARY BYPASS W CARDIAC CATH	110	Quintile 5
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	110	Quintile 5
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	118	Quintile 1
119	VEIN LIGATION & STRIPPING	131	Quintile 2
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	136	Quintile 2
147	RECTAL RESECTION W/O CC	146	Quintile 4
151	PERITONEAL ADHESIOLYSIS W/O CC	150	Quintile 1
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	171	Quintile 3
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	171	Quintile 3
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	171	Quintile 3
158	ANAL & STOMAL PROCEDURES W/O CC	157	Quintile 1
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	178	Quintile 2
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	178	Quintile 2
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	178	Quintile 2
163	HERNIA PROCEDURES AGE 0–17	178	Quintile 2
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	171	Quintile 3
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	171	Quintile 3
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	178	Quintile 2
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	178	Quintile 2
169	MOUTH PROCEDURES W/O CC	178	Quintile 2
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	183	Quintile 2
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	185	Quintile 3
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 3
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	189	Quintile 2
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	193	Quintile 4
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	199	Quintile 3
195	CHOLECYSTECTOMY W C.D.E. W CC	199	Quintile 3
196	CHOLECYSTECTOMY W C.D.E. W/O CC	199	Quintile 3
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	218	Quintile 3
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	218	Quintile 3
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	218	Quintile 3
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0–17	218	Quintile 3
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	229	Quintile 2
232	ARTHROSCOPY	234	Quintile 1
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	234	Quintile 1

CHART 3.—NO VOLUME LTC–DRG CROSSWALK AND QUINTILE ASSIGNMENT [1]—Continued

LTC–DRG	Description	Cross-walked LTC–DRG	Low volume quintile assigned
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17	234	Quintile 1
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	257	Quintile 2
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	257	Quintile 2
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	257	Quintile 2
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	262	Quintile 1
267	PERIANAL & PILONIDAL PROCEDURES	157	Quintile 1
279	CELLULITIS AGE 0–17	278	Quintile 2
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	281	Quintile 2
286	ADRENAL & PITUITARY PROCEDURES	292	Quintile 4
289	PARATHYROID PROCEDURES	290	Quintile 1
291	THYROGLOSSAL PROCEDURES	290	Quintile 1
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	149	Quintile 2
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	297	Quintile 2
309	MINOR BLADDER PROCEDURES W/O CC	311	Quintile 1
313	URETHRAL PROCEDURES, AGE >17 W/O CC	311	Quintile 1
314	URETHRAL PROCEDURES, AGE 0–17	311	Quintile 1
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	326	Quintile 2
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	329	Quintile 1
328	URETHRAL STRICTURE AGE >17 W CC	324	Quintile 2
330	URETHRAL STRICTURE AGE 0–17	329	Quintile 1
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	329	Quintile 1
334	MAJOR MALE PELVIC PROCEDURES W CC	344	Quintile 4
335	MAJOR MALE PELVIC PROCEDURES W/O CC	336	Quintile 3
337	TRANSURETHRAL PROSTATECTOMY W/O CC	341	Quintile 2
338	TESTES PROCEDURES, FOR MALIGNANCY	341	Quintile 2
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	339	Quintile 1
343	CIRCUMCISION AGE 0–17	329	Quintile 1
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	348	Quintile 1
351	STERILIZATION, MALE	348	Quintile 1
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	358	Quintile 5
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	344	Quintile 4
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	344	Quintile 4
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	344	Quintile 4
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	344	Quintile 4
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	149	Quintile 2
362	ENDOSCOPIC TUBAL INTERRUPTION	149	Quintile 2
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	367	Quintile 3
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	369	Quintile 2
370	CESAREAN SECTION W CC	352	Quintile 3
371	CESAREAN SECTION W/O CC	369	Quintile 2
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	369	Quintile 2
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	359	Quintile 1
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	359	Quintile 1
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	359	Quintile 1
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	359	Quintile 1
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	359	Quintile 1
378	ECTOPIC PREGNANCY	369	Quintile 2
379	THREATENED ABORTION	359	Quintile 1
380	ABORTION W/O D&C	359	Quintile 1
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	359	Quintile 1
382	FALSE LABOR	359	Quintile 1
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	359	Quintile 1
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	359	Quintile 1
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	360	Quintile 1
386	EXTREME IMMATURITY	369	Quintile 2
387	PREMATURITY W MAJOR PROBLEMS	369	Quintile 2
388	PREMATURITY W/O MAJOR PROBLEMS	360	Quintile 1
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	369	Quintile 2
391	NORMAL NEWBORN	360	Quintile 1
392	SPLENECTOMY AGE >17	177	Quintile 3
393	SPLENECTOMY AGE 0–17	149	Quintile 2
396	RED BLOOD CELL DISORDERS AGE 0–17	399	Quintile 1
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	400	Quintile 3
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	347	Quintile 2
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	400	Quintile 3
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	410	Quintile 1
412	HISTORY OF MALIGNANCY W ENDOSCOPY	410	Quintile 1
417	SEPTICEMIA AGE 0–17	416	Quintile 3
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	420	Quintile 1
441	HAND PROCEDURES FOR INJURIES	229	Quintile 2

CHART 3.—NO VOLUME LTC–DRG CROSSWALK AND QUINTILE ASSIGNMENT [1]—Continued

LTC–DRG	Description	Cross-walked LTC–DRG	Low volume quintile assigned
446	TRAUMATIC INJURY AGE 0–17	445	Quintile 3
448	ALLERGIC REACTIONS AGE 0–17	455	Quintile 1
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	455	Quintile 1
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	209	Quintile 5
481	BONE MARROW TRANSPLANT	394	Quintile 5
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	55	Quintile 2
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	2	Quintile 5
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	209	Quintile 5
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	209	Quintile 5
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	233	Quintile 4
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	498	Quintile 3
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC	498	Quintile 3
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	506	Quintile 5
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	508	Quintile 3
514	CARDIAC DEFIBRILATOR IMPLANT W CARDIAC CATH	116	Quintile 3
516	PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI	116	Quintile 3
525	HEART ASSIST SYSTEM IMPLANT	111	Quintile 5
526	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI	116	Quintile 3
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	116	Quintile 3

[1] This chart does not reflect the six transplant LTC–DRGs (103, 302, 480, 495, 512, and 513) or the two ''error'' LTC–DRGs (469 and 470), for which we assign a relative weight of 0.0000.

To illustrate the methodology for determining relative weights for the 159 LTC–DRGs with no LTCH cases, we provide the following examples, which refer to the no volume LTC–DRGs crosswalk information provided above in Chart 3:

Example 1: There were no cases in the FY 2001 MedPAR file used for this final rule for LTC–DRG 3 (Craniotomy Age 0–17). Since the period of time surrounding the surgery and the post-operative care are similar in resource use and the length and complexity of the surgical procedures and the length of stay are similar, we determined that LTC–DRG 1 (Craniotomy Age > 17 Except for Trauma), which is assigned to low volume quintile 5 for the purpose of determining the relative weights, displayed similar clinical and resource use. Therefore, we assign the same relative weight of LTC–DRG 1 of 1.8783 (quintile 5) (Table 3 in the Addendum to this final rule) to LTC–DRG 3.

Example 2: There were no LTCH cases in the FY 2001 MedPAR file used in this final rule for LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with bronchitis and asthma are similar in patients regardless of age, we determined that LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 without CC) displayed similar clinical and resource use characteristics and have a similar length of stay to LTC–DRG 91. There were over 25 cases in LTC–DRG 90. Therefore, it is not assigned to a low volume quintile for the purpose of determining the relative weights. However, under our methodology, LTC–DRG 91, with no LTCH cases, needs to be grouped to a low volume quintile. We identified that the quintile with the closest weight to LTC–DRG 90 (0.7921; see Table 3 in the Addendum to this final rule) was low volume quintile 3 (0.8284; see Table 3 in the Addendum to this final rule). Therefore, we assign LTC–DRG 91 a relative weight of 0.08284.

Furthermore, we establish LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512 and 513, respectively) because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare. We only include these six transplant LTC–DRGs in the GROUPER program for administrative purposes. Since we use the same GROUPER program for LTCHs as is used under the acute care hospital inpatient prospective payment system, removing these DRGs would be administratively burdensome. Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs would become certified as a transplant center. In fact, in the nearly 20 years since the implementation of the acute care hospital inpatient prospective payment system, there has never been a LTCH that even expressed an interest in becoming a transplant center.

Again, we note that as this system is dynamic, it is entirely possible that the number of LTC–DRGs with a zero volume of LTCH cases based on the system will vary in the future. We used the best most recent available claims data in the MedPAR file to identify zero volume LTC–DRGs and to determine the relative weights in this final rule.

Table 3 in the Addendum to this final rule lists the LTC–DRGs and their respective relative weights and arithmetic mean length of stay.

B. Special Cases: General

Under section 123 of Public Law 106–113, the Secretary generally has broad authority in developing the prospective payment system for LTCHs. The statute also provides the Secretary with broad authority in determining whether (and how) to make adjustments to LTCH prospective payment system payments. Section 307 of Public Law 106–554 directs the Secretary to ''examine'' appropriate adjustments to the LTCH prospective payment system, including certain specific adjustments, but the Secretary continues to have discretion as to whether to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs.

Generally, LTCHs, as described in section 1886(d)(1)(B)(iv) of the Act, are distinguished from other inpatient hospital settings by maintaining an average length of stay greater than 25 days. However, LTCHs also have certain ''special'' cases that have stays of considerably less than the average length of stay and that receive significantly less than the full course of treatment for a specific LTC–DRG. Such cases would be paid inappropriately if the hospital were to receive the full LTC–DRG payment. Further, because of the budget neutrality requirement of section 123(a)(1) of Public Law 106–113, ''overpayment'' for these ''special'' cases would reduce payments for all other cases that warrant full payment based on the LTCH services delivered. We discuss the special cases below in terms of definitions, policy rationale, and payment methodology.

In the proposed rule, we proposed three subsets of special cases: very short-stay discharges, short-stay outlier discharges, and interrupted stays. In this final rule, in response to comments, we are not adopting our policy concerning very short-stay discharges, and are instead extending a revised short-stay outlier policy to include stays of 1 to 7 days, as explained in the comments and responses regarding short-stay outliers in section X.C. of this preamble. However, we have specifically addressed the comments regarding very short-stay discharges in section X.D. of this preamble. Also, in response to comments, we are simplifying our interrupted stay policy to incorporate a methodology that relies on a fixed number of days to determine payment for readmission from acute care hospitals or IRFs, as explained in section X.E. of this preamble.

C. Special Cases: Short-Stay Outliers

In the March 22, 2002 proposed rule, we proposed to apply a special payment policy to short-stay cases with a length of stay between 8 and two-thirds the average length of stay for each LTC–DRG. We based the proposed policy on the belief that many of these patients could have been treated more appropriately in an acute hospital subject to the acute care hospital inpatient prospective payment system. Therefore, we proposed to implement a short-stay outlier policy for cases with a length of stay beyond 7 days, but not more than two-thirds the average length of stay for the DRG.

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

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

We also believe that providing a reduced payment for short-stay outlier cases neither encourages hospitals to admit patients for whom they knowingly are unable to provide complete treatment in order to maximize payment, nor severely penalizes providers that, in good faith, admit a patient and provide some services before realizing that the beneficiary would receive more appropriate treatment at another site of care. As explained in the proposed rule, establishing a short-stay outlier payment for these types of cases addresses the incentives inherent in a discharge-based prospective payment system for LTCHs for treating patients with a short length of stay. One of the primary objectives of a prospective payment system is to provide incentives for hospitals to become more efficient and, in doing so, to ensure that they can still receive adequate and appropriate payments. Because the LTCH prospective payment system rates are set to be budget neutral, providing a full prospective payment system payment for those cases that do not actually require the full course of treatment would reduce payments for cases that warrant full payment based on the LTCH services furnished. Therefore, we continue to believe that a short-stay outlier policy permits more equitable payment.

In considering possible short-stay outlier policies, we sought to balance appropriate payments to shorter stay cases, which are generally less expensive than the average case in each LTC–DRG, and payments to the more expensive inlier cases (as defined in section X.A.2. of this preamble) in each LTC–DRG. In the absence of a short-stay outlier policy, based on analysis of payment-to-cost ratios, the full LTC–DRG payment would ''overpay'' the short-stay cases and ''underpay'' the inlier cases. We estimated that a short-stay outlier policy that results in payment-to-cost ratios that are at (or close to) 1.0 would ensure appropriate payments to both short-stay and inlier cases within a LTC–DRG because, on average, payments closely match costs for these cases under this prospective payment system.

With no short-stay outlier policy, we estimated that payment-to-cost ratios would be greater than 2.0 for cases with lengths of stay below the average length of stay for the LTC–DRG. In the proposed rule, we considered determining adjustments to the per discharge payment using the following three alternative short-stay outlier threshold policies:

- The least of 100 percent of the cost of the case, 100 percent of the LTC–DRG specific per diem amount multiplied by the length of stay, or the full LTC–DRG payment for cases with a length of stay between 8 days and the average length of stay of the LTC–DRG;
- The least of 150 percent of the cost of the case, 150 percent of the LTC–DRG specific per diem amount multiplied by the length of stay, or the full LTC–DRG payment for cases with a length of stay between 8 days and two-thirds of the average length of stay of the LTC–DRG; or
- The least of 200 percent of the cost of the case, 200 percent of the LTC–DRG specific per diem amount multiplied by the length of stay, or the full LTC–DRG payment for cases with a length of stay between 8 days and half of the average length of stay of the LTC–DRG.

In each of the three alternatives examined, the short-stay outlier day threshold corresponds to the day where the full LTC–DRG payment would be reached by paying the specified percentage of the per diem amount for the LTC–DRG. This would result in a gradual increase in payment as the length of stay increases without producing a ''payment cliff,'' which will provide an incentive to discharge a patient one day later because there will be a significant increase in the payment.

Our analysis in the proposed rule showed that of these three options, in conjunction with the proposed very short-stay discharge policy, the most appropriate policy for short-stay outliers was to adjust the per discharge payment by paying the least of 150 percent of cost, 150 percent of the LTC–DRG per diem amount, or the full LTC–DRG payment. The analysis showed that payment-to-cost ratios for both cases that would be identified as short-stay outliers and inlier cases (that are below the high-cost outlier threshold) will be at or slightly above 1.0. We believed that this alternative would most appropriately pay cases identified as short-stay outliers, inlier cases, and longer stay cases without an incentive to provide inefficient care.

Payment simulations that we conducted for the proposed rule showed that, of the LTCH cases in the FY 2000 MedPAR file with a length of stay between 8 days and two-thirds of the average length of stay of the LTC–DRG under the system, payment to 60.8 percent of those cases would be capped at 150 percent of cost. Therefore, we proposed to define a short-stay outlier as a case that had a length of stay between 8 days and two-thirds of the arithmetic average length of stay for each LTC–DRG (proposed § 412.529). We also proposed to adjust the per discharge payment by paying a short-stay outlier case (defined in proposed § 412.529(a)) the least of: (1) 150 percent of the LTC–DRG specific per diem amount multiplied by the length of stay; (2) 150 percent of the cost of the case; or (3) the full LTC–DRG payment (proposed § 412.529(c)(1)).

We proposed to determine the LTC–DRG specific per diem based payment using the standard Federal payment rate (Federal payment rate × LTC–DRG weight) and the arithmetic mean length of stay of the specific LTC–DRG (proposed § 412.529(c)(2)). We proposed that the cost of a case would be determined using the hospital-specific cost-to-charge ratio and the Medicare allowable charges for the case (proposed § 412.529(c)(3)).

Comment: Several commenters supported the proposed short-stay outlier policy. However, they recommended that this policy also be used as the basis for payment for cases in which the LTCH stay is 7 days or less in lieu of our proposed very short-stay discharge policy.

Response: We appreciate the commenters' support for the short-stay outlier policy and the suggestion to apply it to stays of 7 days or less, which, in the proposed rule, fell under the very short-stay discharge policy. Accounting for stays significantly under the average length of stay in a LTCH is an important feature of a LTCH prospective payment system.

In response to the commenters' recommendation, we reconsidered the policies for both the very short-stay discharge and the short-stay outlier. Policy considerations underlying the short-stay outlier and the proposed very short-stay discharge categories were similar. Patient stays that fell under either category were not likely to have received a full course of treatment and, therefore, for these cases, LTCHs should not receive payment based on the provision of a full course of treatment. Based on the similar policy underpinnings of each policy and our awareness of the payment ''cliff'' effect between stays with a length of stay of 7 days and a length of stay of 8 days, we revisited our data. As a result of our reevaluation, we have determined that we can still meet the goals of our policy considerations by eliminating the very short-stay discharge policy and extending a modified version of the short-stay outlier policy to days 1 through 7 in the LTCH length of stay.

In order to accommodate the addition of cases with a length of stay of 7 days or less to the short-stay outlier payment category, we analyzed numerous data simulations to determine how to reasonably adjust the proposed payment

percentage formula, for example, the lesser of 150 percent of cost or 150 percent of the LTC–DRG specific per diem amount multiplied by the length of stay. If we were to simply maintain the proposed methodology for short-stay outliers and apply it to discharges with a length of stay between 1 and 7 days, we found that we would be ''overpaying'' significantly for those stays and ''underpaying'' for stays categorized as inliers. We considered adjusting the percentage to 130 or 125 percent; however, we found these percentages did not result in payments with an appropriate disincentive for admitting patients who are likely to stay at the LTCH for 7 days or less. After additional simulations, we determined that the most appropriate percentage that maintains a payment-to-cost ratio of approximately 1 for 7 days or less is 120 percent. We determined that if we adjust the payment percentage from 150 to 120 percent, we also need to adjust the upper day threshold from two-thirds of the average length of stay for the LTC–DRG to five-sixths of the geometric average length of stay for the LTC–DRG. As discussed in detail later in this section, we found that five-sixths of the geometric (versus the arithmetic) average length of stay would be the short-stay outlier threshold where the full LTC–DRG payment would be made at 120 percent. That is, by adjusting the per discharge payment by paying at 120 percent of the per diem DRG payment, once a stay reaches five-sixths of the geometric average length of stay for the LTC–DRG, the full DRG payment will have been made. This results in a gradual increase in payment as the length of stay increases. If we retained the original two-thirds of the average length of stay for the LTC–DRG criteria, it would have produced a payment ''cliff'' that would have provided an incentive to extend a patient's stay for one or more days beyond the ''two-thirds average day'' in order to receive a significant increase in payment.

As a result of this analysis, in this final rule, we are revising the short-stay outlier policy to adjust the per discharge payment by paying the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC–DRG payment, for all cases with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC–DRG.

As a consequence of our elimination of the very short-stay discharge policy, the reduction to the percentage from 150 to 120 percent, and the extension of the upper day threshold from two-thirds of the arithmetic average length of stay to five-sixths of the geometric average length of stay, the standard Federal base rate increased from $27,649 in the proposed rule to $34,956 in this final rule. The reduction in the percentage to 120 percent does not necessarily correlate to a reduction in payment under the revised short-stay outlier policy since the 120 percent is applied to a higher LTC–DRG payment. Furthermore, because we are ultimately constrained by maintaining budget neutrality, a change in one policy may require corresponding changes to other policies. However, these changes are not necessarily substantial, and, as a result, the overall effects of our changes in this final rule may be minimal. For example, when we consider how the elimination of the very short-stay discharge policy actually impacts payment under the LTCH prospective payment system for LTC–DRGs 271 and 461, the actual adjusted payment for these DRGs did not change significantly between the proposed rule and the final rule.

Rule	Base rate (BR)	DRG	Description	Relative weight (RW)	Average length of stay (ALOS)	Full DRG payment (BR*RW)	Per diem (full DRG pay/AlOS)	Payment per day at appropriate percentage
Proposed (150%) ..	$27,649	271	Skin Ulcers	1.2354	39.1	$34,158	$873	$1,310
Final (120%)	34,956	271	Skin Ulcers	0.9714	31.1	33,956	1,092	1,310
Proposed (150%) ..	$27,649	416	Septicemia Age >17	1.1222	29.4	$31,028	$1,055	$1,583
Final (120%)	34,956	416	Septicemia Age >17	0.9612	25.9	33,600	1,297	1,557

Thus, despite the reduction of the percentage from 150 to 120 percent, it is evident that the actual payment differences between the two policies are remarkably minimal.

To summarize, the results of the changes in this final rule to the short-stay outlier policy are as follows: (1) The percentage that is applied to determine payment under the short-stay outlier policy is changed from 150 percent to 120 percent; (2) the number of discharges paid as short-stay outliers will increase, due to the inclusion of cases that would formerly have been paid as very short-stay discharges; (3) the upper day threshold for short-stay outliers is extended from two-thirds of the arithmetic average length of stay for a LTC–DRG to five-sixths of the geometric average length of stay for the LTC–DRG; (4) the cases that fell under the very short-stay discharge policy in the proposed rule will now be paid at a higher rate under the revised short-stay outlier policy; (5) the standard Federal base rate will increase, resulting in higher overall payments being made to inliers and a higher base amount upon which short-stay outlier payments are determined; and (6) the fixed-loss amount for high-cost outliers will decrease (see section X.J.6. of this preamble for information on high-cost outliers).

Comment: A number of commenters considered our proposal to pay the least of three payment amounts for short-stay outliers to be too burdensome. They indicated a preference to a one-payment methodology, regardless of the number of days of a patient's stay. Some commenters recommended elimination of the payment related to a percentage of cost because they believed this method creates the wrong incentive and does not reward efficiency. The commenters added that the definition of ''cost'' under the short-stay outlier payment provision is confusing because it is not clear whether the ''hospital-specific cost-to-charge ratio'' used in the proposed rule applies to the current year, the prior year, or some other period.

Response: We do not agree with the commenters that the calculation of the short-stay outlier payment is a burden on the LTCH. The Medicare payment for short-stay outliers using the least of the three payment amounts is determined by the fiscal intermediary with the PRICER software developed specifically for the LTCH prospective payment system. The LTCH is not required to calculate which of the payment options is appropriate for each individual discharge. Rather, the intermediary is responsible for this calculation.

We also do not agree with the commenters that a LTCH's payment should be based on a one-payment

methodology, regardless of the patient's length of stay. As we have stated above, a single payment that does not account for shorter lengths of stay would ''overpay'' the short-stay cases and ''underpay'' the inlier cases. Furthermore, since under this final rule, Medicare will adjust the per discharge payment by paying the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC–DRG payment for cases with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC–DRG, we do not believe a lesser payment based on 120 percent of the cost of the case creates the wrong incentives. Finally, the costs used to determine Medicare payment under the short-stay outlier policy are taken from the cost-to-charge ratio appearing on the most recent cost report as submitted by the LTCH to the fiscal intermediary.

Comment: One commenter indicated that the payment amount for short-stay outliers is too high and provides for reimbursement that exceeds costs by 50 percent.

Response: The commenter is incorrect in stating that, under the proposed rule, payment for short-stay outliers would exceed costs by 50 percent. Under the proposed rule, LTCHs would not have necessarily been provided with a payment that exceeded costs by 50 percent, since the proposed short-stay policy would have paid the least of 150 percent of the cost of the case, 150 percent of the LTC–DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC–DRG payment. Depending on the stay, any one of the three payment categories could have applied, two of which were not related to costs. In addition, the short-stay outlier policy to which the commenters are referring has been changed in the final rule, as explained above. Under the revised short-stay outlier methodology in this final rule, the percentage upon which short-stay outlier payment is based is no longer 150 percent, but is now 120 percent. We prepared extensive payment simulations in order to develop an equitable short-stay payment policy for implementation in the prospective payment system described in this final rule. In reconsidering the policy, we factored in the elimination of the very short-stay discharge policy and the inclusion of days 1 through 7 into the short-stay outlier policy. We determined that the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay, or the full LTC–DRG payment for cases with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC–DRG would be a reasonable payment for short-stay outlier cases. At this percentage, we found that there were still payment-to-cost ratios that provided a disincentive for admission of patients that were likely to stay 7 days or less. We also determined that at 120 percent, stays falling under the short-stay outlier category would not be ''overpaid'' and a larger amount of total payments would be made for the care of true inlier patients.

Comment: Several commenters indicated that the short-stay and very short-stay outlier payment amounts are too low. They recommended that, since short-stay cases have medical therapies and treatment provided on the day of admission, short-stay outliers should be grouped into the appropriate LTC–DRG and paid at 200 percent of the specific LTC–DRG per diem for the first day of admission and 100 percent of the per diem for each day of stay thereafter. Other commenters recommended a 150-percent per diem for the first day and a 100-percent per diem for each day afterward, based on the specific LTC–DRG. Both groups of commenters believe that a policy of an increased payment for the first day of the stay is consistent with our policy on payment for transfers under the acute care hospital inpatient prospective payment system.

Response: As noted above, in response to public comments, we have revised the proposed very short-stay discharge policy. Under the revised short-stay policy, all short-stays, even those with a length of stay between 1 and 7 days, will be grouped into their specific LTC–DRGs. In response to the suggestion that we should provide for an increased payment for the first day of the stay consistent with payments under the acute care hospital inpatient prospective payment system, we call the commenters' attention to the distinctions between the treatment and care of patients at acute care hospitals and the treatment and care at LTCHs. For acute care hospitals, existing regulations at § 412.4(f) establish a payment rate of twice the per diem amount for the first day of the stay at the acute care hospital for the 10 DRGs included in the special transfer rule and payment at the per diem amount for each subsequent day, up to the full DRG payment. This policy presumes that the patient has been admitted as an inpatient to the acute care hospital with an acute medical condition. Even if the patient did not receive a full course of treatment at the acute care hospital and was subsequently transferred to a LTCH or another excluded hospital, SNF, or HHA, the immediate diagnostic care and patient stabilization required during that first day is resource-intensive and costly.

There are several reasons why we do not believe it is appropriate to adopt this policy for short-stays under the LTCH prospective payment system. First, according to research done by Urban, as well as anecdotal reports contained in many of the comments we received, a significant majority of LTCH patients are admitted from an acute care hospital, their medical conditions having been diagnosed and treated and their conditions stabilized to the extent that they can be discharged for additional hospital-level care at a LTCH. In this common situation, we do not believe that the costs incurred on that first day would reasonably exceed by 100 percent, or even by 50 percent, the costs of each subsequent day of hospitalization.

Second, the calculations that determined the daily payments under the short-stay policy were derived from the DRG-specific payment rate that is based on the average length of stay for each LTC–DRG. This means that when the patient is appropriately hospitalized in a LTCH over the course of the stay, any higher costs incurred in the first days of the stay were already accounted for in calculating the LTC–DRG relative weight. Finally, we reiterate that we are not finalizing the proposed very short-stay discharge policy and are instead extending the revised short-stay outlier policy to stays of 7 days or less. We believe that the short-stay outlier policy that we have promulgated in this final rule strikes an appropriate balance between not encouraging the inappropriate admission of short-stay patients to LTCHs while providing reasonable and equitable payments for Medicare patients who may have been admitted in good faith, but whose stays fall in a range below the average length of stay for a LTCH.

Comment: Several commenters believed that the short-stay outlier upper day threshold is too high and pointed to evidence that suggests that under the proposed LTCH prospective payment system, nearly half of all LTCH cases would be reimbursed on a per diem rather than on a discharge basis as required under the law. They believed that having a large number of cases reimbursed on a per diem basis discourages the efficiency of a discharge-based prospective payment system.

The commenters recommended the use of an upper day threshold of one-half the arithmetic average length of stay. They believed this upper day threshold would reduce the high industry-wide portion of cases that would be paid on a per diem basis.

In addition, one commenter noted that the very short-stay discharges were removed from the calculation of the average length of stay for each LTC–DRG, thereby inflating each mean. In effect, the commenter indicated that cases with shorter lengths of stay (1 through 7 days) are not included in calculating the average length of stay; and as a result, the average length of stay for each LTC–DRG is higher. This commenter believed that the application of the threshold of two-thirds to an ''inflated'' average length of stay would penalize LTCHs twice for short-stay outlier patients.

Response: The LTCH prospective payment system in this final rule was designed predominantly to encourage efficiency in LTCHs treating patients requiring long-term hospital-level care. This system functions on a per discharge basis that complies with statutory requirements, and provides for adjustments for concerns specific to LTCHs. In fact, the LTCH prospective payment system is structured so that greater overall dollars are spent on cases that approximate the 25-day average stay of a LTCH patient, which encourages LTCHs to admit and efficiently treat patients who specifically need long-term care. Using the upper day threshold of one-half, as the commenter suggested, may indeed reduce the number of cases paid under the adjusted per discharge short-stay outlier policy. However, for the reasons given in this response, the commenter's suggestion does not comport with the overall goals of the LTCH prospective payment system; and we are not adopting it.

Although the regression analyses and simulations based on prior years' TEFRA data may seem to indicate that nearly half of LTCH cases will be paid on an adjusted per discharge amount, we believe this data analysis does not necessarily predict the future behavior of LTCHs operating under a prospective payment system. The data used in the analysis are a product or reflection of the practice patterns of hospitals that operate under the mechanisms of the TEFRA payment system, which are different from the principles of a prospective payment system. However, these are the best data available upon which we can simulate LTCH behavior under the new LTCH prospective payment system. We believe that once the LTCH prospective payment system is implemented, the practice patterns of LTCHs will change. We anticipate that hospitals will alter their admission, treatment, and discharge patterns. Thus, we fully expect that an increasing majority of cases will be reimbursed on an unadjusted per discharge basis during the transition from reasonable cost-based reimbursement to prospective payments. The transition period of 5 years, designed to allow LTCHs to gradually adapt to the LTCH prospective payment system, should give LTCHs the opportunity to alter admission, discharge, treatment, and transfer patterns as needed for maximum clinical, as well as administrative, efficiency.

Based on our experience in implementing other Medicare prospective payment systems, we fully expect that as new data are received, we may revisit policy decisions described in this final rule. Furthermore, our Office of Research, Development, and Information will be tracking the impact of the prospective payments on LTCHs, other hospitals that treat long-term care patients, and other postacute care providers, which will enable us to determine whether additional policy changes are warranted.

As explained previously, the short-stay outlier upper day threshold corresponds to the day where the full LTC–DRG payment would be reached by paying the specified percentage of the per diem amount for the LTC–DRG. This threshold was chosen to create a gradual increase in payment as the length of stay increases without producing a payment ''cliff''. In the proposed rule, short-stay outlier payments were limited by 150 percent of the per diem amount for the LTC–DRG. Accordingly, the upper day threshold was also established at two-thirds to assure that the full DRG payment would be paid should the patient's stay equal two-thirds of the arithmetic average length of stay of the LTC–DRG.

Because we revised the proposed short-stay outlier policy for this final rule to also apply to discharges that had been proposed to be paid as very short-stay discharges, as requested by the commenters, we also reviewed the methodology for calculating the average length of stay for each LTC–DRG to determine the percentage of discharges that will be treated as short-stay outliers. Although we had originally used the arithmetic mean (which is the most commonly used measure of central tendency) for this calculation in the proposed rule, we now believe that there are certain statistical advantages, such as increased mathematical stability and accuracy, in using the geometric mean for determining the average length of stay for each LTC–DRG in the revised short-stay outlier policy. Lengths of stays within a DRG are log-normally distributed. This is because each individual length of stay may or may not be extremely long, but it cannot be less than zero. A log-normal distribution, by definition, is normal when converted to logarithms. After further simulations and research, we have found that the geometric mean is statistically more accurate in locating the center of the distribution of length of stays within a DRG, which is the result we desire. In addition, geometric weights are not likely to be influenced by a few very long-stay cases and, therefore, are more stable over time. Accordingly, we are revising our calculation for determining length of stay for short-stay outliers to account for the geometric mean. In the acute care hospital inpatient prospective payment system postacute transfer policy (§ 412.4(f)), the geometric mean length of stay for each DRG is used to determine per diem payments. For the reasons outlined above, we believe that it is desirable to adopt a methodology in the final rule consistent with that used in the acute care hospital inpatient prospective payment system.

In this final rule, we have set the per discharge adjustment for each LTC–DRG at 120 percent of the adjusted per diem amount for each LTC–DRG for the short-stay outlier policy. The corresponding upper day threshold that must be established to assure that the full DRG payment is made by the last day of the short-stay outlier payment is five-sixths of the geometric average length of stay of the LTC–DRG. We are aware that this upper day threshold may initially create a situation where there are a higher number of cases that are paid on an adjusted per discharge-basis. However, we expect significant changes in the types of patients admitted to LTCHs, as LTCHs adjust to the prospective payment system, which will reduce the number of patients in LTCHs that are paid as short-stay outliers.

We disagree that our method of calculating the average length of stay for the short-stay outlier policy would penalize LTCHs twice. As the commenter indicated, we do not include days 1 through 7 in the calculation of the average length of stay for each LTC–DRG. Even though we are now incorporating days 1 through 7 into the short-stay outlier payment category, our simulations have indicated that by including these extremely short stays in our mean calculations, the average

length of stay for each LTC–DRG would be inappropriately reduced and would then significantly bias payments against inlier cases. If stays of 7 days or less were included in the calculations of the average length of stay for each LTC–DRG, then the mean of each LTC–DRG would decrease and stays of shorter days would qualify for a full LTC–DRG payment. As the system must be budget neutral, this leads to a situation where more total dollars of payment would be shifted to shorter stays and, therefore, longer stays would receive less payment. We do not believe that it is appropriate to decrease payment to longer stays that actually receive a more representative and complete course of care in order to increase payments to shorter stays. Therefore, in this final rule, we continue to exclude stays of 7 days or less from our calculations of the average length of stay for each DRG, as was provided for in the proposed rule.

In addition, in the proposed rule, cases of 7 days or less were assigned to two specific DRGs in the proposed rule, and their costs were factored into those DRG weights. Although cases that we proposed to be assigned as very short-stay discharges are paid in this final rule under the category of short-stay outliers, we continue to believe that cases with stays of up to 7 days should not be included in the calculation of relative weights. This is because DRG relative weights should reflect the average of resources used on representative cases of a specific type. Stays of 7 days or less do not receive or benefit from treatment that is typical in a LTCH stay. Full resources are not used in the earlier stages of admission to a LTCH. If we did include stays of 7 days or less in the computation of the relative weights, the value of most weights would decrease and, therefore, inlier payments would decrease. We do not believe that it is appropriate to compromise the integrity of the payment determination at the expense of those inlier cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include these very short-stays in the computation of the relative weights. (As noted in section X.A.2. of this preamble, stays of 8 days or over are included in the calculations of the relative weights on a fractional basis.)

Nevertheless, for payment purposes, we are treating LTCH stays of 7 days or less as short-stay outliers, since we believe that a LTCH should not be penalized for those occasions when, in good faith, it admits a patient, who shortly after admission, expires or is transferred to a more appropriate setting. We also believe that incorporating payments for stays of 7 days or less into the final short-stay outlier formula considerably simplifies the payment system.

After consideration of the public comments received and reevaluating our proposed policy, we are adopting as final a short-stay outlier policy that will apply to all LTCH admissions with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC–DRG. The short-stay outlier policy will pay the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay for that discharge, or the full LTC–DRG payment.

D. Proposed Payments for Special Cases of Very Short-Stay Discharges

As mentioned earlier in section X.B. of this preamble, in the March 22, 2002 proposed rule, we proposed at § 412.527 to define a very short-stay discharge as a discharge that has a length of stay of 7 days or less (regardless of the LTC–DRG assignment), irrespective of the discharge designation (including cases where the patient expires). We indicated that a very short-stay discharge often occurs when it is determined, following admission to a LTCH, that the beneficiary would receive more appropriate care in another setting. For example, a patient may experience an acute episode or require more intensive rehabilitation therapy than is available at the LTCH. Other circumstances that we believed would warrant classification as a very short-stay discharge would involve patients who were either discharged to their home or who expired within the first 7 days of being admitted to a LTCH.

Since LTCHs are defined by statute as generally having an average length of stay greater than 25 days, we proposed to make an adjustment for very short-stay discharges in order to make appropriate payment to cases that may not necessarily require the type of services intended to be provided at a LTCH or may have been transferred from an acute hospital prematurely. Further, we believed that providing a special payment for very short-stay discharges neither encourages hospitals to admit patients for whom they knowingly are unable to provide complete treatment in order to maximize payment, nor severely penalizes providers that, in good faith, admit a patient and provide some services before realizing that the beneficiary will receive more appropriate treatment at another site of care.

As stated in the proposed rule, we also believed that establishing a special payment for a discharge with a very short length of stay is critical in implementing a discharge-based prospective payment system. Because the rates are set to be budget neutral, if we did not make an adjustment for stays significantly shorter than the average length of stay in a LTCH, providing a full prospective payment system payment for very short-stay LTCH cases would inappropriately reduce payments for nonshort-stay LTCH cases.

To improve the accuracy of the payments, we proposed to categorize very short-stay discharge cases into two categories based on the primary diagnosis—one for psychiatric cases and one for all other types of cases. We believed it would be appropriate to separate very short-stay discharge cases into psychiatric and nonpsychiatric categories because our analysis showed that the resources used to treat these two types of patients during the first 7 days differ significantly. In our simulations, combining psychiatric very short-stay discharge cases with all other very short-stay discharge cases resulted in a considerable ''overpayment'' for the very short-stay discharge psychiatric cases and a substantial ''underpayment'' of all other (nonpsychiatric) very short-stay discharge cases. A detailed explanation of the proposed split of very short-stay outliers into two categories and the proposed assignment to LTC–DRGs appears in the proposed rule published in the **Federal Register** on May 22, 2002 (67 FR 13453–13454). We proposed to calculate the relative weights for the two very short-stay discharge LTC–DRGs using the hospital-specific relative value methodology. The very short-stay discharge LTC–DRG per diem amount would have been determined by dividing the applicable Federal payment rate (Federal payment rate × LTC–DRG weight) by 7 days.

Comment: Many of the commenters questioned the basis for treating cases with a length of stay of 7 days or less as very short-stay discharges. They indicated that the policy ignores the difficult clinical decisions that LTCHs consistently face daily and that the policy will severely penalize providers who in good faith admit a patient, but the patient exhausts their Medicare Part A number of day benefits within 8 days of admission, or the patient's condition worsens and later needs treatment elsewhere, or the patient dies. They added that the very short-stay policy would create financial incentives for LTCHs to avoid patients close to the end of Medicare coverage for hospital stays, but who need LTCH care. These commenters suggested that the very short-stay policy be abandoned in favor

of an extension of the short-stay outlier policy to cases that have stays of 7 days or less.

Some commenters urged us to eliminate the ''cliff'' between the payment of a 7-day very short-stay and the payment of an 8-day short-stay outlier, which could be as much as $10,000, depending on the DRG. They indicated that this ''cliff'' could encourage LTCHs to keep patients extra days simply to receive the windfall that occurs at day 8 and suggested that we apply the proposed short-stay outlier policy to all stays of 7 days or less.

Response: Our data analyses of the MedPAR files from FY 1999 through FY 2000 originally led us to differentiate between LTCH stays of 7 days or less and those of more than 7 days, but still considerably less than the average length of stay for the LTC–DRG to which the stay was grouped. (See section X.C. for our discussion on short-stay outliers.) However, after reconsidering the policy in light of the commenters' concerns, including the need to eliminate the incentive for LTCHs to keep patients additional days simply to receive the monetary windfall that occurs with a payment ''cliff'', we have decided to eliminate this category of patient stays, and instead, extend the now revised short-stay outlier policy to stays of 7 days or less, as discussed in detail in section X.C. of this final rule.

The short-stay outlier policy, when extended to stays of 7 days or less, addresses our concerns of ''overpaying'' for incomplete treatment, while also recognizing and appropriately compensating LTCHs for expenses related to treating patients that have a shortened length of stay due to deaths or for care of patients who are not actually discharged, but whose Medicare coverage is exhausted within 7 days or less of their admission. (The issue of deaths occurring within the first 7 days is discussed in more detail in the next comment.) Specifically, with regard to the commenters' concerns about patients who exhaust their Medicare coverage in 7 days or less of their stay in the LTCH, since many LTCH patients are admitted to a LTCH following a hospitalization at an acute care hospital, it is possible that a patient who could benefit from continued medical care at a LTCH could have used up the maximum 150 Medicare days allowed for that spell of illness. We wish to clarify that under the final rule, Medicare payments for patients that have 7 days or less remaining days of Medicare coverage will receive payment based on the revised short-stay outlier policy in this final rule.

With respect to patients whose conditions suddenly worsen within the first 7 days of admission, while the ultimate outcome for any given patient may be difficult to predict at the time of admission, LTCHs by and large should be admitting patients who predictably need the particular type of care that LTCHs offer. LTCH patients often present with multiple comorbidities, but their overall condition in most cases should be relatively stable if they were discharged from an acute care hospital and do not require the intense intervention associated with acute care hospitals. Further, in admitting such patients, we believe that LTCH personnel should determine that these patients actually require and can benefit from hospital-level care for what is intended to be an average stay of greater than 25 days. Even if a LTCH is focusing on admitting the appropriate types of patients, it may still infrequently admit patients whose conditions suddenly worsen. We believe that the number of unpredictable cases would be small, and payment for simpler cases, requiring fewer resources, should typically balance out higher cost cases of stays that are 7 days or less that are unforeseeable.

In addition, we note that with the elimination of the very short-stay discharge policy, most cases with a stay of 7 days or less will now be paid at the higher DRG-specific short-stay outlier rate. Moreover, for the highly unusual phenomenon of a short-stay case that actually falls into the high-cost outlier category, outlier payments will be available once the patient's costs exceed the payments under the short-stay outlier policy and the fixed loss threshold, under § 412.525.

Based on our policy revision regarding the elimination of the very short-stay discharge payment category, we do not anticipate any penalty, as described by the commenter, for stays of 7 days or less that were admitted in good faith. In establishing a payment category for shorter stays that, in an increasing progression, reflects the LTCH resources used for a specific episode of care, we believe that we have effectively and equitably addressed the problem of treating short-term patients in a LTCH.

We appreciate the comments concerning the ''payment cliff,'' which potentially could have provided a significant incentive for LTCHs to keep patients who would otherwise have been paid for as very short-stay discharges. Our concern also about this ''cliff'' effect created by payments under the proposed very short-stay policy contributed to our decision to eliminate the policy. In this final rule, we are establishing a policy for all cases with a length of stay up to and including five-sixths of the geometric average length of stay of the specific LTC–DRG (including stays of 7 days or less). These cases will be paid under the short-stay outlier policy, thus eliminating the incentives present with the ''cliff.'' Under the short-stay outlier policy, there will be a steady daily increase in payments beginning with the first day, without a windfall payment on any given day, as described in section X.C. of this preamble, and LTCHs will be encouraged to base discharge decisions on clinical judgment rather than on financial gain.

Comment: Some commenters indicated that the severity of a LTCH patient's medical condition is typically very high upon admission, requiring significant resources and resulting in high costs within the first several days. The commenters pointed out that the DRG weights assigned to the proposed very short-stay discharges for determining the payment ignores this fact. As a result, LTCHs would not receive adequate reimbursement for these services. The commenters pointed out that there are high costs associated with patients who receive high intensity ''code blue'' services, including patients who expire. They recommended the establishment of a separate DRG for patient expiration cases that would have a higher case weight than the proposed very short-stay discharge DRGs.

Response: While we understand the commenters' concerns, we point out that, even under the now eliminated proposed very short-stay discharge policy, payment was based on two LTC–DRGs, one for psychiatric cases and one for nonpsychiatric cases. The computation of the weights for those LTC–DRGs did include total charges for all such cases, and generally, payments would have been based on LTC–DRG weights that have balanced out the most complex admissions with the simpler admissions. Under the final rule, payments for stays of 7 days or less will likely be higher under the revised short-stay outlier policy that we are adopting as outlined in section X.C. of this preamble, and payments will be LTC–DRG specific, with rates reflecting relative medical complexity and severity of a patient condition. We believe that this revision in our short-stay policy addresses the commenters' concerns.

With regard to the commenters' suggestion that we create a separate DRG to compensate for the high costs associated with patients who expire, with our elimination of the proposed

very short-stay discharge policy, payments for these patients will also be paid under the short-stay outlier policy. Under the short-stay outlier policy, each case is classified into a LTC–DRG and the per diem payment adjustment is based on our calculations of relative resource use for that LTC–DRG. As we note in section X.A. of this preamble, LTC–DRG weights were derived from data simulations that were adjusted for short-stay outliers and included deaths that occurred prior to the short-stay outlier threshold for each LTC–DRG. In addition, adjusted payments for each case that fall within the short-stay outlier category, based on the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay, or the full LTC–DRG payment, should generally compensate for any increased costs associated with treating a severely sick patient who dies. Moreover, in keeping with the principles underlying prospective payments, even if a hospital did not profit, or even recover its costs for a specific case, there are other cases for which the hospital will receive payment in excess of its costs. Therefore, we do not believe that a separate DRG is necessary for patient expiration cases.

Accordingly, based on our analysis of the public comments received and our further evaluation of the proposed very short-stay policy, we have decided not to implement the very short-stay policy as proposed. We are removing the proposed § 412.527 from the regulation text and not adopting it as final. Instead, we are extending the short-stay outlier policy to all stays up to and including five-sixths of the geometric average length of stay for the specific LTC–DRG, as discussed in detail under section X.C. of this preamble.

E. Special Cases: Interrupted Stay

In the March 22, 2002 proposed rule, we proposed to define cases involving an interruption of a stay in a LTCH as those cases in which a LTCH patient is discharged to an inpatient acute care hospital, an IRF, or a SNF for treatment or services not available at the LTCH for a specified period followed by readmittance to the same LTCH (§ 412.531). For a discharge to an acute care hospital, the proposed period of interruption was within (less than or equal to) one standard deviation from the arithmetic average length of stay for the DRG assigned for the inpatient acute care hospital stay. For a discharge to an IRF, the proposed period of interruption was within one standard deviation from the arithmetic average length of stay for the CMG and the comorbidity tier assigned for the IRF stay. For a discharge to a SNF, the proposed period of interruption was within 45 days in a SNF (that is, one standard deviation from the average length of stay for all Medicare SNF cases).

In considering an appropriate proposed interrupted stay threshold, we attempted to balance the payment incentives of both the LTCH and the acute care hospital, IRF, or SNF to which the LTCH patient is discharged before being readmitted to the LTCH. In order to assure that discharges from LTCHs are based on clinical considerations and not financial incentives, we proposed that the interrupted stay day threshold would only pay the LTCH for more than one discharge if the patient's length of stay at the acute care hospital, IRF, or SNF exceeded one standard deviation from the average length of stay for the DRG, the combination of the CMG and the comorbidity tier, or for all Medicare SNF cases, respectively. We believed this would have made it more difficult for a LTCH to find a prospectively paid acute care hospital, IRF, or SNF that would admit a LTCH patient just to allow the LTCH to receive two separate LTC–DRG payments.

We believed that the proposed interrupted stay day threshold of one standard deviation from the average length of stay for either the acute care hospital DRG, the IRF combination of the CMG and the comorbidity tier, or for all Medicare SNF cases would provide the appropriate disincentive since cases that stay significantly longer than the average length of stay are more costly than the average case. Since the SNF prospective payment system is a per diem system and not a per discharge system, we proposed to implement the same threshold for all SNF cases regardless of the resource utilization group (RUG) classification used for SNF payment. We believed the proposed interrupted stay threshold was appropriate because, in general, the average length of stay plus one standard deviation would capture the majority of the discharges that are similar to the average length of stay for the respective DRG, combination CMG and comorbidity tier, or for all Medicare SNF cases. In addition, this proposal was consistent with the basis for our payment policy for new technologies under the acute care hospital inpatient prospective payment system where the cost of a new technology must exceed one standard deviation beyond the mean standardized charge for all cases in the DRG to which the new technology is assigned in order to receive additional payments (see the September 7, 2001 inpatient hospital final rule, 66 FR 46914). Under the proposed rule, the counting of the days for the interruption of the stay would begin on the day of discharge from the LTCH and end on the day the patient is readmitted to the LTCH.

For the purposes of payment under the LTCH prospective payment system, we proposed that a case that meets the definition of an interrupted stay would be considered a single discharge from the LTCH, and, therefore, would receive only one LTC–DRG payment. Since the two LTCH stays are considered as a single case for the purposes of payment under the LTCH prospective payment system, the second discharge from the LTCH is included in the single LTC–DRG payment. The acute care hospital, the IRF, or the SNF stay would be paid in accordance with the applicable payment policies for those providers.

We also proposed to make one discharge payment under the LTCH prospective payment system for an interrupted stay case, as defined under § 412.531(a), to reduce the incentives inherent in a discharged-based prospective payment system of ''shifting'' patients between Medicare-covered sites of care in order to maximize Medicare payments. We believed that the proposed policy was particularly appropriate for LTCHs since, as a group, these hospitals are considerably diverse and offer a broad range of services such that where some LTCHs may be able to handle certain acute conditions, others will need to transfer their patients to acute care hospitals. (Section V.C. of this preamble contains a description of the universe of LTCHs.)

For instance, some LTCHs are equipped with operating rooms and intensive care units and are capable of performing some surgeries. However, other LTCHs are unable to provide those services and will need to transfer the beneficiary to an acute care hospital. Similarly, a patient who no longer requires hospital-level care, but is not ready to return to the community, could be transferred to a SNF. This incentive to ''shift'' patients between Medicare-covered sites of care in order to maximize Medicare payments is of a particular concern when the LTCH is physically located within the walls of another hospital. Often, the LTCH patient may not even be aware of a transfer to the other hospital or SNF because he or she will have only been moved down the hall or to another wing of the building. Moreover, our research reveals that hospitals-within-hospitals are the fastest growing type of LTCH. We also believe that the same incentives

for inappropriate discharges and readmittance exist for satellite LTCHs that are located within acute care hospitals, described in § 412.22(h), as well as for distinct part SNFs co-located with LTCHs. (We address the particular issues of onsite discharges and readmittances in section X.G. (§ 412.532(d)) in this final rule.)

We proposed that whether or not a LTCH patient who is discharged to an inpatient acute care hospital, an IRF, or a SNF and then returns to the same LTCH is treated as an interrupted stay (with one LTC–DRG payment) or as a new admission (with two separate LTC–DRG payments) depended on the patient's length of stay at the acute care hospital, IRF, or SNF compared to the arithmetic average length of stay and the standard deviation for the acute care hospital inpatient prospective payment system DRG, the IRF combination of the CMG and the comorbidity tier, or 45 days for all Medicare SNF cases. In the proposed rule, we specified in tables the arithmetic average length of stay and one standard deviation for each acute care hospital DRG and each IRF combination of the CMG and the comorbidity tier. (As noted above, this was not necessary for SNFs, as we used a set number of days for SNF stays in the proposed rule.)

While the proposed interrupted stay policy under § 412.531 was based in part on clinical considerations, we realized that it may be somewhat administratively burdensome for the LTCH to determine the DRG for the acute care hospital stay or the combination of the CMG and the comorbidity tier for the IRF stay, in order to determine whether or not a beneficiary who is discharged to an acute care hospital or an IRF and then returns to the LTCH would be an interrupted stay (with a single LTCH prospective payment system payment) or a new admission (with two separate LTCH prospective payment system payments). Therefore, we discussed in the proposed rule our intent to further analyze Medicare claims data to determine if we should consider treating all patients who are discharged to either an acute care hospital or an IRF and admitted back to the LTCH within a fixed number of days (as we had proposed for SNFs), regardless of the DRG of the patient in the acute care hospital or the combination of the CMG and the comorbidity tier of the patient in the IRF, as an interrupted stay. We indicated that 9 days for acute care hospitals and 27 days for IRFs might be appropriate thresholds to identify interrupted stay cases because, in both cases, the thresholds are one standard deviation from the average length of stay of all patients in those respective settings. We were aware that, under such a policy, less clinically complex brief acute care hospital and IRF stays would be included and would become an interrupted stay if the beneficiary returns to a LTCH. However, those types of cases would be offset by other stays that require more intensive and lengthy care.

For this final rule, we have decided to treat all patients who are discharged to either an acute care hospital or an IRF and admitted back to the LTCH within a fixed period of time (as we did in the proposed rule for discharges to SNFs), regardless of the DRG or the combination CMG and comorbidity tier, as an interrupted stay. This decision will relieve the administrative burden on providers and eliminate the need to make claims billing system changes, as discussed in our responses to the first two public comments in this section. We believe that 9 days for acute care hospital stays and 27 days for IRF stays are appropriate thresholds to identify interrupted stay cases because, in both cases, the thresholds are one standard deviation from the average length of stay of all patients in those respective settings. We are retaining as final the proposed 45-day threshold for SNFs.

Comment: Over half of the commenters objected to our proposed policy for determining the LTC–DRG payment for an interrupted stay (with a single LTCH prospective payment system payment) based on a number-of-day threshold that equals one standard deviation from the average length of stay for the DRG for the acute care hospital or the IRF combination of CMG and comorbidity tier for the IRF stay. The same commenters did not object to the proposed policy for SNFs, because it used a specified number of days (45) for all stays in a SNF for computing the period of interruption.

The commenters believed that (1) the proposed methodology for acute care hospitals and IRF stays would be an extreme administrative burden on providers; (2) it would be difficult for LTCHs to determine assigned DRGs and CMGs and comorbidity tiers and length of stays (discharge and readmittance dates) during the interruption for these cases; and (3) the proposed policy would be too costly for both providers and intermediaries to implement within the Medicare claims billing and data systems. Some commenters believed there might be an issue of possible compromise of the Privacy Rule relating to disclosure of certain individually identifiable patient health information to certain entities under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Response: In the proposed rule, we acknowledged that it might be somewhat administratively burdensome to determine the DRG for the acute care hospital stay or the combination of the CMG and the comorbidity tier for the IRF stay in order to determine whether or not a beneficiary who is discharged to an acute care hospital or an IRF and then returns to the LTCH will be considered an interrupted stay (with a single LTCH prospective payment system payment) or a new admission (with two separate LTCH prospective payment system payments). For that reason, we solicited specific comments on an alternative methodology.

We have further evaluated our proposal and agree that LTCHs might be unnecessarily burdened if they were required to determine the other facility's assigned DRGs and CMG and comordibity tiers for the interruption and that numerous changes would have to be made to the Medicare billing and data systems to implement the policy. As a result, we agree with the commenters that it is more feasible to implement the proposed alternative methodology for determining the LTC–DRG payment for interrupted stays based on a fixed day threshold for each provider level of care, as discussed in our response to the next comment. This policy change should relieve most of the administrative burden that the commenters were concerned with and eliminate the need to determine the DRGs and CMGs and comorbidity tiers assigned to the patient at the other facility. In response to the commenters' concern regarding HIPPA, even under the proposed rule, we do not believe privacy implications under HIPPA would have been implicated.

Comment: In response to our request for alternatives to the proposed methodology for determining the interruption of stay threshold, commenters recommended several methodologies for assigning a fixed number of days of absences at each provider level for determining an interrupted stay. Specifically, some commenters agreed with our proposed alternatives of a 9-day threshold for acute care hospital stays, a 27-day threshold for IRF stays, and retention of the 45-day threshold for SNF stays. One commenter believed that the 45-day threshold for SNFs is too long. Other commenters recommended one of the following for all sites: (1) A 9-day threshold, regardless of the service codes or discharge setting; (2) a threshold range of 10 to 12 days or 11 days or less; or (3) a fixed threshold that

reflects the average length of stay of hospitalizations for all DRGs. Two commenters recommended not including any interrupted stay policies in the final rule. One commenter suggested that any positive or negative effects of the 9-day, 27-day, and 45-day thresholds on budget neutrality as set forth in the proposed rule be adjusted through the standard Federal payment amount.

Response: After consideration of the public comments and our further analysis of MedPAR data, we are revising the proposed thresholds under our interrupted stay policy, as it relates to discharges to acute care hospitals and IRFs, to incorporate a fixed period of time. For this final rule, we have decided to treat all patients who are discharged to either an acute care hospital or an IRF and admitted back to the LTCH within a fixed period of time (as we did in the proposed rule for discharges to SNFs), regardless of the DRG or the combination CMG and comorbidity tier, as an interrupted stay. We believe that 9 days for acute care hospital stays and 27 days for IRF stays are appropriate thresholds to identify interrupted stay cases because, in both cases, the thresholds are set at one standard deviation from the average length of stay of all patients in those respective settings. We are retaining in the final rule the proposed 45-day threshold for SNFs. We do not agree with the commenter who stated that the 45-day threshold for SNFs is too long. A length of stay of 45 days is the average number of days plus one standard deviation for all SNF Medicare patients. In addition, we are not adopting the commenters' suggestion that we dispense with the interrupted stay policy because we believe this policy is an essential component of the LTCH prospective payment system, as explained elsewhere in this section.

In response to the comment about the impact that any revised interrupted stay policy will have on the budget neutrality calculations, we wish to assure the commenter that the interrupted stay policy in this final rule is one of several policies that have been revised based on public comments and taken into consideration in developing the final standard Federal prospective payment rates for FY 2003. The recalibration of the prospective payment rates in this final rule based on those revisions will continue to satisfy the statutory requirement for budget neutrality.

Comment: Some commenters believed the payment system should not penalize those providers who make clinically appropriate transfers. Four commenters indicated that, based on experience, the number of readmissions to LTCHs are minimal, especially from IRFs and SNFs, and questioned CMS data on interruptions of stays at LTCHs. These commenters objected to the proposed interrupted stay policy because they believed it would impose a significant burden solely to prevent certain questionable transfers that rightfully should be reviewed on an individual basis for appropriateness.

Response: We proposed making one payment under the LTCH prospective payment system for an interrupted stay to preserve the integrity of the per discharge LTCH prospective payment system. We are not attempting to restrict a LTCH from pursuing necessary clinical care from another facility. However, we do not believe it is appropriate for the LTCH to receive a second payment for a patient if the patient returns to the LTCH to complete treatment already begun in the LTCH at the time of the earlier admission. Nowhere in the interrupted stay policy are we suggesting that the treatment at the secondary site would be unnecessary or clinically inadvisable. In addition, we believe that LTCHs, certified as acute care hospitals, should generally be able to handle nonsurgical urgent care needs. Therefore, the need to transfer should not arise as frequently as it might from a different provider. While we did not base this policy on specific data, and at this point we cannot quantify the number of readmissions to LTCHs, the interrupted stay policy is intended, in part, to reduce the incentives inherent in a discharge-based prospective payment system of ''shifting'' patients between Medicare-covered sites of care in order to maximize Medicare payments. We believe that payment under this policy is fair and is particularly appropriate for LTCHs since, by definition, the hospital treats patients with an average length of stay of greater than 25 days, and while payments are determined based on average lengths of stay, there may be an incentive for the LTCH to discharge the patient for part of that stay to another hospital. We believe we have eliminated the significant burden that the commenters were concerned with by revising the threshold criteria, as discussed earlier.

Comment: A few commenters suggested that cases that are readmitted to the LTCH from another facility in less than the specified timeframe should be treated as separate cases under the LTCH prospective payment system if the second admission to the LTCH is unrelated to the primary reason for the initial admission.

Response: As noted above, under the interrupted stay policy that we are adopting in this final rule, if the patient's length of stay away from the LTCH does not exceed the fixed day thresholds, the return to the LTCH is considered part of the first admission and will be paid as one admission. The situation the commenters describe is, and will continue to be, viewed as one stay. In section VIII. of this preamble, we provide details on patient classifications by DRG and highlight the fact that the principal diagnosis and secondary diagnoses form the basis upon which a LTC–DRG will be assigned for the entire stay. On the other hand, if the patient exceeds the total fixed day threshold outside of the LTCH at another facility before being readmitted, two separate LTC–DRG payments would be made, one based on the principal diagnosis for the first admittance and the other based on the principal diagnosis for the second admittance. If the principal diagnoses are the same for both admissions, the hospital could receive two similar payments.

If the LTCH stay were not interrupted, the patient still could have developed other indications or complicating factors while in the LTCH. In this situation, grouping for the LTC–DRG would be based predominantly on the principal diagnosis, along with data from complicating secondary or additional diagnoses, any procedures, and age, gender, and discharge status as is done under the acute care hospital inpatient prospective payment DRG system. However, secondary diagnoses that have no bearing on the LTCH stay may be discarded by the GROUPER software when classifying cases for the purposes of determining payment. The presence of additional diagnoses does not automatically generate a comorbid or complicating condition for all DRGs, as explained in section IX.E. of this preamble relating to the ICD–9–CM coding system. In a situation of an interrupted stay or a stay that is not considered an interrupted stay, comorbidity could develop and the principal diagnosis would still be the factor most significantly affecting the DRG assignment.

The acute care hospital inpatient prospective payment system, upon which we based the LTCH prospective payment system, treats one stay at an acute care facility similarly, where cases are classified into DRGs for payment based on the patient's principal diagnosis. Additional or secondary diagnoses may be recorded and may slightly influence DRG assignment for a case. However, the principal diagnosis,

with which the patient originally entered the acute care facility, is the dominant indicator for the DRG assignment.

In addition, the typical LTCH patient has multiple, complex medical problems represented by several ICD–9–CM codes that will be listed on any one patient's claim. If we were to allow a new LTC–DRG assignment after an interrupted stay based solely upon whether one of these other conditions had increased in severity, it would not be difficult for the LTCH to select a different principal diagnosis following the patient's return to the LTCH. Medicare would then make two payments for what was, in reality, one single episode of treatment for the type of patient who is ideally suited for hospitalization in a LTCH, a very sick patient with multiple comorbidities.

A DRG-based prospective payment system is designed to set payment at an average of hospital charges for all admittances of a particular type of diagnosis. This average should reflect more complex and costly cases along with cases that require less care. As cases are paid based on an average, some less resource intensive cases of the same diagnosis will receive the same payment as more resource intensive cases. Overall, under prospective payment systems, hospitals that are efficient will receive fair compensation. We believe that this payment system ultimately results in more equitable payments for LTCHs.

Comment: One commenter questioned why there is not an interrupted stay policy for discharge and readmittance between one LTCH and another LTCH.

Response: In our data, we did not find that transfers between LTCHs occurred frequently enough to require a separate policy. However, we will be monitoring LTCH behavior and if, in the future, we become aware of data that indicate that this activity is occurring, we would revisit this issue.

Comment: One commenter questioned whether the following scenario would be considered an interrupted stay: a LTCH patient is discharged to an acute care hospital for 3 days, the acute care hospital then discharges the patient to a SNF for 43 days, and then the patient is readmitted to the LTCH.

Response: In this final rule, the interrupted stay policy only encompasses situations where a patient is discharged from a LTCH to another facility and then readmitted directly from that one facility to the same LTCH. It does not address situations where the patient is admitted to more than one facility or goes home between LTCH stays. Our data did not show this situation to be a significant problem. Therefore, at this time we are not extending the interrupted stay policy to this situation. Currently, a patient admitted to a LTCH who is subsequently discharged to home or to at least two other facilities before readmission at the LTCH will be paid for as two admissions, and not be subject to the interrupted stay policy. However, we will continue to monitor LTCH readmissions and should the above example, where the LTCH patient has multiple short stays in several facilities before readmission, prove to be significant, we will consider proposing a change in policy.

Comment: One commenter asked whether, for hospitals paid under the 5-year transition, an interrupted stay under the LTCH prospective payment system would still qualify as two discharges for TEFRA payment purposes.

Response: As explained earlier in section VIII. of this preamble, we are implementing a 5-year transition period from reasonable cost-based reimbursement to fully Federal prospective payment for LTCHs. During this period, two payment percentages will be used to determine a LTCH's total payment. The blend percentages can be found in sections II.D. and X.N. of this final rule. The interrupted stay policy will apply to the portion of the blended percentage that represents the prospective payment Federal rate percentage.

TEFRA policy on readmissions will apply to the portion of the blended percentage that represents the reasonable cost-based reimbursement percentage. Under TEFRA policy, each admission and discharge is counted separately as two discharges with no consideration given to the length of stay at another facility before readmission. However, there is one scenario when, even under the TEFRA payment policy, two discharges from a LTCH will be counted as one stay for payment purposes. There are specific TEFRA regulations governing readmission to excluded hospitals, such as LTCHs, with regard to hospitals-within-hospitals at § 413.40(a)(3) (July 30, 1999, **Federal Register**, 64 FR 41535). During a cost reporting period, if the hospital-within-a-hospital discharges more than 5 percent of its inpatients to another co-located hospital, and those patients are directly readmitted to the excluded hospital, Medicare considers each patient's entire stay as one discharge for purposes of calculating the cost per discharge of the excluded hospital. This policy is still in effect for the TEFRA portion of the payment blend for long-term care hospitals-within-hospitals. (For more information on how a hospital-within-a-hospital would be paid under the LTCH prospective payment system, see section X.G. of this preamble, which outlines onsite discharge and readmission policy.) Therefore, other than this particular scenario for LTCHs that are hospitals-within-hospitals, for an episode of patient care that, under the LTCH prospective payment system, would be paid as an interrupted stay, the portion of payments under TEFRA paid to LTCHs during the transition period will continue to count separately for each discharge from the LTCH.

Accordingly, based on the public comments received and our further analysis of Medicare claims data, in this final rule we are adopting the proposed interrupted stay policy as final with the following changes. We are revising the interrupted day threshold so that patients who are discharged from a LTCH to an acute care hospital and readmitted to the LTCH within a 9-day period of time will be considered as an interrupted stay and only a single LTCH prospective payment system payment will be made. To be considered an interrupted stay for patients who are discharged from the LTCH to an IRF and readmitted to the LTCH, the fixed day threshold is 27 days. We are retaining as final the proposed 45-day threshold for discharges from a LTCH to a SNF and readmission to the LTCH. Any readmissions to a LTCH from these three provider levels of care that are subsequently discharged from the LTCH that involve interruptions that are longer than these thresholds will be treated as new admissions and two separate LTCH prospective payments will be made.

We wish to point out that an interrupted stay could occur during a regular inlier case (length of stay greater than five-sixths of the geometric average length of stay for the LTC–DRG), as described in section X.A. of this final rule. A short-stay outlier (as explained in section X.C. of this preamble) could also become an interrupted stay if the beneficiary is discharged to an acute care hospital, an IRF, or a SNF. Whether or not the beneficiary's stay would remain in this category depends on the total length of stay in the LTCH. Upon the initial discharge to the acute care hospital, the IRF, or the SNF, the LTCH ''day count'' would stop. For an interrupted stay case, this count is resumed upon readmission to the LTCH until the beneficiary's final discharge (home, another site of care, or death). Thus, the period of absence (number of days) that the beneficiary is a patient in

the acute care hospital, the IRF, or the SNF during a LTCH interrupted stay is not included in determining the length of stay of the LTCH stay.

If the total number of days at the LTCH, from the initial admission to the final discharge, still falls into the short-stay outlier payment category, the LTCH receives payment according to the short-stay outlier policy described in section X.C. of this preamble. If, on the other hand, the total number of days in the LTCH exceeds five-sixths of the geometric average length of stay of the LTC–DRG (the short-stay outlier criteria), one full LTC–DRG payment is made for the case. Moreover, all applicable payment policies, including outliers and transfers for the acute care hospital inpatient prospective payment system and the IRF prospective payment system still apply under this policy.

The following are examples of possible ways in which these policies would interact:

Example 1: A beneficiary stays in the LTCH for 5 days and is discharged to an inpatient acute care hospital and the length of stay at the acute care hospital is greater than 9 days before being discharged and readmitted back to the LTCH. Medicare hospital payments for this beneficiary are as follows:

- One short-stay outlier LTCH prospective payment system payment to the LTCH for the first (5-day length of stay) LTCH discharge.
- Payment to the acute care hospital under the acute care hospital inpatient prospective payment system for the acute care stay.
- A separate LTCH prospective payment system payment either as a short-stay outlier (see § 412.529) or regular inlier case (as described in section X.A.2. of this preamble), depending on the second LTCH length of stay.

This case would not be an interrupted stay because the acute care hospital stay was greater than 9 days, which represents more days than one standard deviation from the average length of stay under the acute care hospital inpatient prospective payment system for all DRGs.

Example 2: A beneficiary stays in the LTCH for 5 days and is discharged to an inpatient acute care hospital and the length of stay at the acute care hospital is a number of days that is 9 days or less before being discharged and readmitted back to the LTCH. The beneficiary remains in the LTCH for an additional 9 days after readmission to the LTCH following the acute care hospital stay. This case would be treated as an interrupted stay and Medicare hospital payments for this beneficiary would be as follows:

- Payment to the acute care hospital under the acute care hospital inpatient prospective payment system for the DRG for the acute care hospital stay.
- The stay was interrupted because the acute care hospital stay was 9 days or less. Therefore, a single payment will be made to the LTCH under the LTCH prospective payment system. This payment would be a short-stay outlier payment (under § 412.529) if the total LTCH length of stay (14 days) is up to and including five-sixths of the geometric average length of stay of the LTC–DRG. If the total LTCH length of stay is greater than five-sixths of the geometric average length of stay of the LTC–DRG, then the LTCH would receive the full DRG payment.

Example 3: A beneficiary stays in the LTCH for 5 days and is discharged to an IRF and the length of stay at the IRF is 27 days or less. The beneficiary is readmitted to the LTCH for an additional 12 days, so that the combined 17 days is greater than five-sixths of the geometric average length of stay for the LTC–DRG after readmission to the LTCH following the IRF stay. This case will be an interrupted stay and Medicare hospital payments for this beneficiary will be as follows:

- Payment to the IRF under the IRF prospective payment system for the combination of the CMG and the comorbidity tier for the IRF stay; and
- Since the stay was interrupted because the IRF stay was within one standard deviation from the geometric average length of stay at an IRF, a single payment will be made under LTCH prospective payment system. This payment will be a full LTC–DRG payment because the total LTCH length of stay is greater than five-sixths of the geometric average length of stay of the LTC–DRG.

In Example 2 and Example 3, upon return to the LTCH following the discharge from the acute care hospital or the IRF, the day count will be resumed at day 6 of the LTCH stay. If the beneficiary was then discharged within a period that is up to and including five-sixths of the geometric average length of stay for the LTC–DRG, the stay will be paid as a short-stay outlier (see § 412.529); and if the beneficiary was discharged beyond the short-stay threshold (five-sixths of the geometric average length of stay for the LTC–DRG), the case will be paid for the full LTC–DRG.

F. Other Special Cases

Under other Medicare prospective payment systems, specifically for inpatient acute care hospitals and for IRFs, there are separate policies for other types of special cases such as transfer cases and patients who expire. As stated in the proposed rule, we continue to believe the short-stay outlier policy (under § 412.529) and the interrupted stay policy (under § 412.531) will adequately address these circumstances. For instance, a case with a stay that is up to and including five-sixths of the geometric average length of stay of the LTC–DRG will be paid under the short-stay outlier policy regardless of whether or not the patient is transferred upon discharge to his or her home or to another setting where Medicare will make additional payments, or whether the patient expired. Moreover, if a beneficiary's stay at the LTCH is greater than five-sixths of the geometric average length of stay of the LTC–DRG, a full LTC–DRG payment will be made regardless of the destination following discharge. Therefore, in this final rule, we are not implementing a separate policy for cases that are transferred (except for those that are encompassed by the interrupted stay policy) or for patients who expire.

Currently, under the acute care hospital inpatient prospective payment system, discharges in 10 DRGs are considered to be transfers if the patients are discharged to another Medicare postacute site of care, such as a LTCH, under section 1886(d)(5)(J)(ii) of the Act and implemented in regulations at § 412.4. The rationale behind this provision was Congressional concern that Medicare may, in some cases, be ''overpaying hospitals for patients who are transferred to a postacute care setting after a very short acute care hospital stay.'' (Conference Agreement, H.R. Conf. Rept. No. 105–217, 105th Cong., 1st Sess., at 740 (1997).) In such a scenario, Medicare will also have to pay the postacute care provider for care that theoretically could have been provided at the acute care hospital. Section 1886(d)(5)(J)(iv) of the Act authorizes the Secretary to expand the postacute care transfer policy to additional DRGs. From the standpoint of LTCHs, the impact of expanding the acute care hospital inpatient prospective payment system postacute care transfer policy could be significant for the LTCH prospective payment system since this policy could affect behavior at acute care hospitals. If additional discharges will be paid as transfers, these patients may be kept longer at acute care hospitals in order to avoid a reduced payment for the transfer and then have a shorter length of stay during the subsequent stay at the LTCH. Presently, approximately 70 percent of LTCH Medicare patients are admitted following discharge from an acute care hospital. In the FY 2003 acute care hospital inpatient prospective payment system proposed rule (67 FR 31455), we solicited public comment on the feasibility of an expansion of the postacute care transfer policy (10-DRG policy). However, based on the public comments received, as described in the acute care hospital inpatient prospective payment system final rule on August 1, 2002 (67 FR 50048–50052), we decided not to expand this policy for FY 2003, but to further study the issue for consideration at a later date.

Comment: One commenter argued against a possible expansion of the inpatient acute hospital postacute care transfer policy to LTCHs because of its possible effects on LTCHs.

Response: As we indicated above, we have decided to postpone any expansion of the postacute care transfer policy under the acute care hospital inpatient prospective payment system until we have done further study and evaluation.

G. Onsite Discharges and Readmittances

As we explained above, we do not believe that a separate policy governing transfers of Medicare patients between LTCHs and acute care hospitals is necessary at this time. However, we are implementing a policy that will address transfers between LTCHs and distinct-part SNFs, acute care hospitals, IRFs, or psychiatric facilities when the LTCH and any of these other providers are co-located because of the potential for inappropriate shifting of patients among these providers without clinical justification to maximize Medicare payment. This situation may occur when a distinct-part SNF is part of a LTCH or when the LTCH is located within an acute care hospital or an IRF as either a ''hospital-within-a-hospital (as defined in § 412.22(e)) or a ''satellite facility'' (as defined in § 412.22(h)) and a distinct-part SNF (as defined in section 1819(a) of the Act) is also part of the same acute care hospital or IRF. (Section V.C.9. of this preamble describes findings from Urban's research on the admission and discharge patterns between LTCHs and SNFs.)

Similarly, a long-term care ''hospital-within-a-hospital'' or satellite facility may be co-located with a psychiatric or rehabilitation hospital that is also a hospital within the same acute care hospital or is a satellite facility situated in the same acute care hospital (§§ 412.25 and 412.27), or may be co-located in an acute care hospital with a psychiatric unit (§ 412.27) or a satellite psychiatric or rehabilitation unit (§ 412.25(e)).

We believe that a per discharge system, such as the prospective payment system for LTCHs, could provide inappropriate incentives to prematurely discharge patients to one of these other onsite providers once their lengths of stay at the LTCH exceeded the thresholds established by the short-stay outlier policies described in section X.C. of this preamble. These discharges will be based on payment considerations rather than on a clinical basis as an extension of the normal progression of appropriate patient care. If the long-term care hospital-within-a-hospital inappropriately discharges Medicare patients to the distinct-part SNF, or the onsite IRF, psychiatric facility, or acute care hospital without providing a complete episode of hospital-level care, Medicare will make inappropriate payments to the long-term care hospital-within-a-hospital, since payments under the prospective payment system will have been calculated based on a complete episode of such care. This type of a case could then be followed by a readmission to the LTCH from the onsite provider for an additional LTC–DRG payment. (In the case of a discharge from a LTCH to an offsite acute care hospital, an IRF, or a SNF with a subsequent return to the LTCH, payments will also be considered under the interrupted stay policy set forth at section X.E. of this final rule and at § 412.531.)

In determining an appropriate response to onsite discharges and readmittances, we are implementing a policy consistent with our policy described in the July 30, 1999 acute care hospital inpatient prospective payment system final rule (64 FR 41535) that addresses inappropriate discharges of patients between an acute care hospital inpatient prospective payment system excluded hospital-within-a-hospital (such as a LTCH) to the host acute care hospital, that culminated in a readmission to the hospital-within-a-hospital. In that context, we expressed the same concern noted above—that these types of moves were occurring for financial rather than clinical reasons. In order to discourage these practices, we implemented regulations at § 413.40(a)(3) to specify how to calculate the cost per discharge under the excluded hospital payment provisions. Under those regulations, during a cost reporting period, if the hospital-within-a-hospital discharges more than 5 percent of its inpatients to the acute care hospital where it is located, and those patients are readmitted to the excluded hospital-within-a-hospital, Medicare considers each patient's entire stay as one discharge for purposes of calculating the cost per discharge of the excluded hospital-within-a-hospital. In determining whether a patient has previously been discharged and then readmitted, we consider all prior discharges, even if the discharge occurs late in one cost reporting period and the readmission occurs in the next cost reporting period. Only when the excluded hospital's number of cases involving a discharge from the excluded hospital-within-a-hospital to the host acute care hospital followed by a readmission to the hospital-within-a-hospital exceed 5 percent of the total number of its discharges in a particular cost reporting period are the first discharges not counted for payment purposes. (If the 5-percent threshold is not triggered, all discharges are counted separately.)

With the implementation of the per discharge prospective payment system for LTCHs, in this final rule and in the proposed rule, we are adopting a similar policy to address inappropriate discharges and readmittances between LTCHs and other onsite providers by establishing a threshold beyond which the original patient stay and the readmission will be paid as one discharge (see § 412.532). By paying only one discharge, we will discourage those transfers that will be based on payment considerations instead of on a clinical basis. Generally, if a LTCH readmits more than 5 percent of its Medicare patients who are discharged to an onsite SNF, IRF, or psychiatric facility, or to an onsite acute care hospital, only one LTC–DRG payment will be made to the LTCH for discharges and readmittances during the LTCH's cost reporting period. Therefore, payment for the entire stay will be paid either as one full LTC–DRG payment or a short-stay outlier, depending on the duration of the entire LTCH stay.

In applying the 5-percent threshold, we will apply one threshold for discharges and readmittances with a co-located acute care hospital, consistent with the policy that has been in place under § 413.40(a)(3) for acute care hospitals and excluded hospitals described above. There will also be a separate 5-percent threshold for all discharges and readmittances with co-located SNFs, IRFs, and psychiatric facilities. In the case of a LTCH that is co-located with an acute care hospital, an IRF, or a SNF, the onsite discharge and readmittance policies would apply in addition to the interrupted stay policy that we discussed in section X.E. of this preamble and at § 412.531. This means that even if a discharged LTCH patient who was readmitted to the LTCH following a stay in an acute care hospital of greater than 9 days, if the facilities share a common location and the 5-percent threshold were exceeded, the subsequent discharges from the LTCH will not represent a separate hospitalization for payment purposes, so only one LTC–DRG payment will be made.

Similarly, if the LTCH has exceeded its 5-percent threshold for all discharges to an onsite IRF, SNF, or psychiatric hospital or unit with readmittances to the LTCH, the subsequent discharges

will not be treated as a separate discharge for Medicare payment purposes, notwithstanding provisions of the interrupted stay policy with regard to lengths of stay at an IRF or a SNF (see §§ 412.531(b)(4)(ii) and (b)(4)(iii)). (As under the interrupted stay policy, payment to an acute care hospital under the acute care hospital inpatient prospective payment system, to an IRF under the IRF prospective payment system, and to a SNF under the SNF prospective payment system, will not be affected. Payments to the psychiatric facility also will not be affected.) We are aware that situations could arise where, under sound clinical judgment, a patient who no longer required LTCH–level of care could be discharged to a SNF and then experience a setback necessitating rehospitalization. However, it is likely that, in such a scenario, in most cases the patient will be subsequently admitted to an acute care hospital rather than readmitted to the LTCH located within the acute care hospital. In addition, as we stated in the proposed rule, if the patient is being treated by a LTCH that also specializes in treating psychiatric or rehabilitation patients, it is unlikely that the patient who, for some medical reason, needed to be transferred to an onsite psychiatric or rehabilitation hospital or unit, will need to be readmitted to the LTCH. We believe that the 5-percent thresholds for discharges to onsite acute care hospitals and for discharges to onsite IRFs, SNFs, and psychiatric facilities followed by readmission to the LTCH provide adequate flexibility for those rare circumstances where such actions would be clinically preferable.

We continue to believe that the combination of a discharge-based payment system that inherently contains financial incentives for shifting patients to another site of care and the close proximity of other sites of care such as other onsite hospitals-within-hospitals, satellites, and distinct-part SNFs, necessitates this type of policy. We will monitor such discharges and analyze data and compare practice patterns before and after the implementation of the LTCH prospective payment system and, if warranted, may consider extending it to offsite providers.

Comment: Several commenters urged us to postpone implementation of this policy pending the collection of data or a formal study confirming that patient-shifting abuses among co-located providers are actually occurring.

Response: As we note in section X.I. of this final rule, we will be developing a monitoring system that would, among other things, assist us in evaluating the impact of the LTCH prospective payment system on patient care patterns among Medicare providers. We are sufficiently concerned about the growth in the number of co-located providers and the inappropriate shifting of patients to co-located providers. Therefore, we disagree with commenters that our onsite discharges and readmittances policy should be postponed. As noted above, we have designed this policy in order to discourage patient-shifting for other than clinical purposes. In addition, our policy for onsite discharges and readmittances is consistent with the policy originally described in the July 30, 1999 acute care hospital inpatient prospective payment system final rule (64 FR 41535) which addressed inappropriate discharges from an excluded hospital paid under the TEFRA system, such as a LTCH, that was co-located as a hospital-within-a-hospital to a host acute care hospital, culminating in the readmission to the LTCH. In establishing this onsite policy (as well as the interrupted stay policy discussed in section X.E. of this preamble) for separately located providers, there has been no attempt to discourage the transfer of a Medicare patient at a LTCH to another onsite provider for treatment not available at the LTCH or for nonhospital level care available in a SNF. However, we have established regulations regarding a patient's subsequent readmission to the LTCH immediately following the discharge from this other onsite provider, a circumstance that we believe could have less clinical justification than the initial LTCH discharge and admission to the other onsite provider. We continue to believe that the two 5-percent thresholds in this final rule for readmittances to the LTCH prior to the triggering of payment consequences for the LTCH provide sufficient flexibility for those unusual cases when such action could be clinically warranted.

Comment: Several commenters noted that the onsite discharge and transfer policy was unnecessary since the interrupted stay policy already addressed our concerns in this area. In addition, one commenter stated that readmissions to freestanding LTCHs equaled those to onsite LTCHs and that an additional onsite policy imposed expensive and unnecessary recordkeeping responsibilities on providers.

Response: Notwithstanding the concerns that led us to establish our interrupted stay policy, we believe that the very nature of co-located Medicare providers provides an even stronger incentive for unnecessary patient shifting and must be discouraged at the outset of establishing prospective payments for LTCHs. Unless and until a LTCH exceeds the 5-percent threshold for readmittances from the onsite acute care hospital or the 5-percent threshold for readmittances from onsite IRFs, psychiatric hospitals or units, or SNFs, Medicare payments will be based on the interrupted stay policy. This means that if a LTCH patient is admitted to one of these other providers following a LTCH hospitalization, and then readmitted to the LTCH, the length of stay at the intervening provider will determine whether the LTCH hospitalizations are paid as one or more discharges. Should one of the 5-percent thresholds be exceeded, all LTCH readmissions from either the acute care hospital or the IRF, SNF, and psychiatric facility combined for that cost reporting year will be paid as one discharge, regardless of the length of stay at the intervening provider.

We wish to clarify that if, for example, the 5-percent threshold for onsite discharges and readmissions is exceeded during a particular cost reporting period between the co-located LTCH and the acute care hospital, all onsite discharges and readmittances between these two providers during that cost reporting period will be paid as one discharge, even those that occurred prior to the threshold having been exceeded. This would also be the case for onsite discharges and readmissions that exceed the combined 5-percent threshold for IRFs, SNFs, and psychiatric facilities that are co-located with a LTCH.

This policy reflects our concerns about patient transfers among co-located providers that are based on financial rather than medical considerations. As noted above, although a patient's discharge from a LTCH to another Medicare provider could represent a reasonable sequence of care, the direct admission of that patient to the LTCH should be a relatively rare occurrence. However, if over 5 percent of the total number of patients who are discharged from a LTCH during a cost reporting period are subsequently directly readmitted from a co-located provider, we believe that such behavior signifies a pattern of inappropriate patient-shifting among onsite Medicare providers and, therefore, we will treat all of the patients in that site of care group who are discharged and readmitted as if they are only one discharge and make only one LTC–DRG payment for those discharges.

We do not believe that the onsite policy (or the interrupted stay policy as it has been revised in this final rule)

imposes an additional burden on providers since the standard of care in clinical practice requires tracking a patient's recent medical history upon admission, and sound hospital management requires ongoing evaluation of discharge and readmittance patterns.

Comment: Several commenters urged us to support, with research, any extension of the onsite policy to Medicare providers that are not co-located with LTCHs.

Response: Our monitoring of all LTCH discharges and readmittances as we implement the LTCH prospective payment system will yield data that will enable us to determine whether extension of this policy is warranted.

Comment: One commenter pointed to the distinction between co-located and co-owned hospitals. Two commenters sought to clarify what was meant by the category of ''co-located'' or ''onsite'' providers. Another commenter suggested that we apply the onsite policy with regard to SNFs only to those SNFs that are co-located in the same building.

Response: There is clearly a distinction between the co-location and co-ownership of Medicare providers, although some hospitals and units are both co-located and owned by the same corporate entity. Governing regulations at § 412.22(e) and (f) for hospitals-within-hospitals and § 412.22(h) and (i) for satellite facilities, and at § 412.25 for satellite units place no restriction on hospital or unit ownership. As we monitor the implementation of the LTCH prospective payment system, we will be noting the impact of ownership and location patterns, among others, in our evaluation of existing payment policy.

We are defining ''co-located'' and ''onsite'' for purposes of the policy established under § 412.532, in accordance with existing definitions for hospitals-within-hospitals and satellite facilities. Under § 412.22(e), hospitals-within-hospitals are defined as ''* * * hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital * * *'' Satellite facilities are defined in § 412.22(h) as ''* * * a part of a hospital that provides inpatient services in a building that is also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.'' The definition of ''campus'' is set forth in § 413.65(a)(2). In this final rule, we have revised § 412.532 to specifically reference these definitions. We do not see any basis for us to change these definitions only for SNFs and, therefore, we will be categorizing onsite SNFs by the same standards as that used for other Medicare providers.

Comment: Two commenters expressed concern that, in promulgating a policy that discouraged onsite patient transfers, we were ignoring the fact that SNFs were a logical destination for LTCH patients upon completion of their course of treatment. These commenters believed that we should not establish payment disincentives for a LTCH that discharges a patient to a co-located SNF.

Response: We agree with the commenters that, in some instances, a patient's placement in a SNF following hospitalization in a LTCH is a reasonable sequence of care. Our onsite discharge and readmission policy does not challenge the initial discharge from the LTCH or admission to the SNF, but rather the subsequent readmission to the LTCH directly from the onsite SNF. We do not believe that our onsite transfer policy discourages appropriate onsite patient transfers. Under the LTCH prospective payment system, if, during a cost reporting period, a LTCH readmits more than 5 percent of its total number of Medicare patients from an onsite or co-located SNF, IRF, or psychiatric hospital or unit or readmits more than 5 percent of its patients from an onsite acute care hospital (in both situations, generating a second admission to the LTCH for that patient), the Medicare program will pay the LTCH for only one discharge in such cases for all patient discharges and readmittances from that provider or group of providers during that cost reporting period. The principal goal of our onsite discharge and readmission policy is to discourage patient-shifting from one Medicare site of care to another so that Medicare will pay only once for a particular episode of illness.

Existing ownership regulations do not guard against the potential gaming of the Medicare system in this way by a corporate entity owning both co-located providers (as well as an onsite acute care hospital, an IRF, or a psychiatric hospital or unit). Therefore, our policies under the LTCH prospective payment system have been designed to discourage financially motivated movement of patients among onsite Medicare providers. We also believe that the two distinct 5-percent thresholds allow for those unusual circumstances when therapeutic judgment could reasonably dictate a patient's readmission to the onsite LTCH from the other onsite provider to which the patient had been originally discharged.

Comment: One commenter, a corporation that owns IRFs, suggested that the onsite discharge and readmission policy should limit readmissions to LTCHs to 5 percent total readmissions from all co-located providers (acute care hospitals, IRFs, psychiatric facilities, and SNFs) rather than 5 percent from an onsite acute care hospital and 5 percent from an onsite IRF, SNF, and psychiatric facility combined.

Response: We believe that the 2 distinct 5-percent onsite discharge and readmission thresholds are based on a realistic understanding of current treatment patterns at LTCHs and provide adequate flexibility for clinical decisionmaking. When we were designing the onsite discharge and readmission policy, we took into account research by Urban that detailed sources and destinations of LTCH patients. As we noted in our discussion of the universe of LTCHs in section V.C. of this final rule, most LTCH patients who are transferred to other sites of care go to acute care hospitals. Therefore, at one end of the spectrum were patients who required further acute care, and at the other end, patients who no longer required LTCH-level care. Our two 5-percent threshold policies recognize that there are two distinct groups of patient groups being discharged from LTCHs: (1) Those requiring more intensive, acute hospital care; and (2) those whose medical conditions have stabilized or improved so that they can receive care at an IRF, a psychiatric facility or to a SNF.

We believe that it is appropriate that acute care hospitals have a separate 5-percent threshold, and since fewer patients go to SNFs, IRFs, and psychiatric facilities, a collective 5-percent threshold for those facilities is adequate.

Comment: Two commenters questioned how we would actually implement the onsite discharge and readmission policy from a systems perspective.

Response: In order to practically implement payments under the onsite discharge and readmission policy, fiscal intermediaries will reconcile Medicare payments and discharge data received by LTCHs during the course of that cost reporting year, at the close of each cost reporting period. We will issue program memoranda detailing instructions for fiscal intermediaries and providers regarding billing, data collection, and systems operations following the publication of this final rule.

Comment: One commenter supported reducing the incentives to transfer patients inappropriately, but also

expressed concern that our onsite policy may not take into account the clinical needs of Medicare patients and could discourage even appropriate transfers. The commenter further suggested that Medicare's QIO should monitor patient care at LTCHs in general and onsite readmissions in particular. Another commenter believed that our onsite policy constrained clinical decisionmaking and restricted a Medicare beneficiary's choice of provider.

Response: We appreciate the commenter's support for our policy efforts regarding inappropriate transfer of patients among onsite Medicare providers. While we agree that the decision to move a patient from one care setting to another should be made on purely clinical grounds, we remain concerned about discharges based on financial concerns, particularly among Medicare providers that are both co-located and owned by the same parent corporation. In this final rule, we are establishing a payment policy for LTCHs based on our best available data. We are not prohibiting a LTCH from serving a patient nor have we dictated where a patient should receive care. For this reason, we will retain the onsite discharge and readmission policy as we implement the LTCH prospective payment system. Regarding review by QIOs, we have established medical review requirements at § 412.508(a) in accordance with existing regulations at §§ 412.44, 412.46, and 412.48 and consistent with other established prospective payment systems policies. As noted throughout this final rule, we expect that the implementation of the LTCH prospective payment system will generate data that will allow indepth analysis and evaluation of our policies. To that end, we have established a monitoring protocol with our Office of Research, Development, and Information.

H. Additional Issues for Onsite Facilities

1. Issues Proposed for Discussion in the March 22, 2002 Proposed Rule (67 FR 13416)

As we prepare to implement a prospective payment system for LTCHs, we are reevaluating certain existing policies for hospitals-within-hospitals and satellite facilities that were established under the TEFRA payment system for excluded hospitals.

Existing regulations at § 412.22(e) specify exclusion criteria based on ownership and control for hospitals-within-hospitals and their host hospitals (59 FR 45330, September 1, 1994). We are concerned about possible manipulation of Medicare payments by a single entity that owns or controls an acute care hospital and a co-located LTCH. We believe that such a situation could lead to premature patient discharges from the acute care hospital to the co-located LTCH, resulting in two Medicare payments to the controlling entity for one episode of care. Since LTCHs are generally capable of providing a wide range of medical treatment, we are concerned about the following scenario: the costs of treating an acute care hospital patient exceed the payment that the hospital would receive for that specific DRG and the acute care hospital ''discharges'' the patient who still requires treatment, for admission to an onsite LTCH. Under this circumstance, the LTCH would, in fact, function as an excluded unit of an acute care hospital, a situation inconsistent with section 1886(d)(1)(B) of the Act, which allows excluded rehabilitation and psychiatric units in acute care hospitals but not long-term care units. Through the interrupted stay and onsite discharge and readmittance policies set forth in sections X.E. and X.G., respectively, of this final rule, which limit potential inappropriate Medicare payments, we believe that we have addressed some of the concerns that originally led us to establish the rules in § 412.22(e).

In the March 22, 2002 proposed rule, we solicited comments on possible changes to our payment policy regarding ownership and control for hospitals-within-hospitals.

Comment: Two commenters supported maintaining the existing regulations governing hospitals-within-hospitals and further endorsed the proposed interrupted stay and co-located discharge and readmittance provisions. Several commenters encouraged stricter enforcement of our present policy on control and ownership. The commenters believed that, even though our regulations require hospital-within-hospitals to have separate governing bodies, chief medical officers, separate medical staffs and chief executive officer from host hospitals (§ 412.23(e)(1) through (e)(4)) and require basic hospital functions to be separated according to the fulfillment of one of three criteria at § 412.23(e)(5), some hospitals-within-hospitals and their host hospitals have managed to circumvent the regulations. One of these commenters noted that, in such situations, the long-term care hospitals-within-hospitals were, in effect, functioning as LTCH units.

Response: The expressed intent of existing separateness criteria at § 412.22(e), first presented in the September 1, 1994 acute care hospital inpatient prospective payment system final rule (59 FR 45390 and 45396), was to disallow the formation of a single hospital facility that included an acute care hospital paid under the prospective payment system and what would effectively be a LTCH unit that would be paid under the TEFRA payment system. We believe that formation of such a facility was contrary to the statutory intent of section 1886(d)(1)(B) of the Act. The existing regulations were implemented to prohibit such an arrangement. As we implement the prospective payment system for LTCHs, we remain extremely concerned about rapid growth in long-term care hospitals-within-hospitals and will be collecting data on the relationship among host hospitals, hospitals-within-hospitals, and parent corporations in order to determine the need for additional regulation or monitoring.

Comment: Ten commenters urged us to strengthen existing separateness criteria in the regulation. Among the policies suggested were disallowing the establishing of separate corporations with common ownership and funding to operate a hospital-within-hospital by parent or controlling companies or host hospitals; precluding the provision of goods and services not consistent with ''fair market value''; and the guaranteeing of the long-term care hospital-within-hospital's loans or debts by the host hospital. Commenters pointed to loopholes in existing regulations that allow corporations to evade our intent. One hospital association urged us to disallow a parent company of the host hospital to establish a separate corporation that would control both the host hospital and finance a hospital-within-a-hospital. Another commenter proposed a percentage ceiling on patients that a long-term care hospital-within-a-hospital could admit from the host hospital, a strict definition of ''direct'' and ''indirect'' control for purposes of limiting common corporate ownership. One commenter noted that, although the forthcoming LTCH prospective payment system onsite discharge and admission policies (section X.G. of this final rule and § 412.532) could deter LTCHs from financially benefiting from discharging patients and subsequently readmitting them, acute care hospitals could still make financially driven transfers of patients to LTCHs.

Response: We believe that existing regulations, including the existing 10-DRG postacute care transfer policy at § 412.4, are effective disincentives for acute care hospitals to transfer patients, for whom they could reasonably provide

treatment, to LTCHs. However, as noted below, we are requiring all LTCHs to inform their fiscal intermediary and their CMS Regional Office if they are co-located Medicare providers and will be collecting data on the corporate relationships between these providers. We plan to revise our policies and take action as necessary if our research reveals circumvention of CMS policy goals.

Comment: One commenter suggested that an additional criteria to prevent abuse by hospitals-within-hospitals would be to strengthen the regulations about disclosure of other alternatives as part of hospital discharge planning, one of the Medicare conditions of participation for hospitals, as described in § 482.43.

Response: Discharge planning is one of our basic hospital health and safety requirements. Under § 482.43(b)(6), a hospital is currently required to discuss the results of the discharge planning evaluation with the patient or individual acting on the patient's behalf. In addition, §§ 482.43(c)(4) and (c)(5) already require the hospital to reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan and to counsel and prepare patients and family members for posthospital care. Accordingly, based on these existing safeguards, we do not believe that there is a need to modify § 482.43.

Comment: Five commenters urged us to refrain from issuing any additional regulations affecting hospitals-within-hospitals, particularly relating to ownership of a hospital-within-a-hospital. Two commenters recommended the elimination of all LTCH ownership rules, and one commenter suggested that we consider ''leveling the long-term acute care hospital playing field''. The commenter believed that such action would allow true competition and remove any unnecessary barrier to general acute care hospitals entering into the long-term acute care hospital business.

Response: We believe it essential to establish regulations discouraging the transfer of Medicare patients from one provider to another for any reason other than for clear clinical benefits of the patient. However, without the separate ownership and control requirements at § 412.22(e), we believe that LTCHs located within a host acute care hospital could function as LTCH units. This is a prospect that is inconsistent with the purpose and scheme of section 1886(d)(1)(B) of the Act, which provides for the exclusion of psychiatric and rehabilitation units, but not for the exclusion of LTCH units. The acute care hospital inpatient prospective payment system was originally based on the principle of determining an average cost per discharge, and the average was determined by including all discharges, short and long stays. For an acute care hospital to move its patients to a ''LTC unit'' rather than treating the patient for the entire spell of illness would allow the hospital to have had the benefit of a payment for that patient that had been based on including long-stay patients in calculating the average cost per discharge, while in actuality no longer treating those longer stay types of patients.

In our final rule for the acute care hospital inpatient prospective payment system (September 1, 1994 **Federal Register** (59 FR 45389)), we noted that we intended for the hospital-within-hospital policy to allow ''adequate flexibility for legitimate networking and sharing of services * * *'' and we believe that existing policies can contribute to efficiency, convenience and clinical benefits. Whether or not we will promulgate additional ownership and control regulations for hospitals-within-hospitals will be based on the results of our collection and analysis of data that we will be gathering for monitoring and compliance purposes.

Comment: Several commenters urged us to publish a proposed rule to provide the opportunity for public comments for any proposed changes to the regulations governing hospitals-within-hospitals.

Response: At this point, we do not have specific plans to revise any existing policies on hospitals-within-hospitals. As we implement the LTCH prospective payment system, we will be monitoring hospitals-within-hospitals and satellite facilities for, among other behaviors, compliance with existing regulations, growth in numbers, and transfer patterns. In order to facilitate this monitoring and compliance, we are requiring that LTCHs notify their fiscal intermediaries and their CMS regional office about their co-location with any other Medicare providers by December 1, 2002 (within 60 days following the initial effective date of the LTCH prospective payment system).

Therefore, we are revising the regulations at §§ 412.22(e) and 412.22(h) to incorporate this required notification. If, as a consequence of these monitoring activities, we determine that we need to revisit existing regulations dealing with ownership and control of hospitals-within-hospitals, we will follow the notice and comment rulemaking process.

Comment: One commenter, a LTCH that is co-located, as a hospital-within-a-hospital with a larger tertiary care center that is an acute care hospital, with both facilities having a common owner, asserted that the single ownership of both hospitals actually affords significant benefits to patients in the LTCH from the standpoint of clinical care as well as medical efficiency and management.

Response: We agree with the commenter's assertion that the location of a long-term care hospital-within-a-hospital co-located within a host acute care hospital has a number of advantages from the standpoint of patient convenience and management, provided the requirements set forth in § 412.22(e) are satisfied and the patients in each of the co-located hospitals receive a full episode of care in that hospital.

Comment: One commenter suggested that the prospective payment system for LTCHs take into account that freestanding LTCHs have considerably higher infrastructure costs than LTCHs that exist as hospitals-within-hospitals.

Response: The Urban Institute's research based on FY 1997 cost reports from LTCHs revealed that there is no significant difference between the payment-to-cost ratios for LTCHs that exist as hospitals-within-hospitals and freestanding LTCHs. We expect to update these data and, therefore, as noted above, we are revising the regulations at §§ 412.22(e) and (h) to require LTCHs to notify their fiscal intermediaries and their CMS regional office of their co-location with any other Medicare providers within 60 days of their first cost reporting period that begins on or after October 1, 2002. These data will enable us to evaluate possible cost differentials between LTCHs that are co-located and those that are freestanding. As we analyze the data, we will determine if and what payment system adjustments would be appropriate to propose.

Comment: One commenter questioned whether we were soliciting comments on the possibility of allowing LTCHs to house units of other excluded hospital categories, such as rehabilitation or psychiatric units.

Response: Under § 412.25(a)(1)(ii), a unit excluded from the acute care hospital inpatient prospective payment system is precluded from locating in a facility that is excluded from the acute care hospital inpatient prospective payment system, such as a LTCH. We have no plans to revise this policy.

We also solicited comments on our policy regarding LTCHs that have established satellite facilities. In § 412.22(h)(1), we define a satellite as ''a part of a hospital that provides inpatient

services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.'' Satellite arrangements exist when an existing hospital that is excluded from the acute care hospital inpatient prospective payment system and that is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e) shares space in a building or on a campus occupied by another hospital in order to establish an additional location for the excluded hospital. The July 30, 1999 acute care hospital inpatient prospective payment system final rule (64 FR 41532–41534) includes a detailed discussion of our policies regarding Medicare payments for satellite facilities of hospitals excluded from the acute care hospital inpatient prospective payment system. In the March 22, 2002 proposed rule, we indicated that we would consider the possibility of revisiting the policies we established for these satellites. In accordance with section 1886(b) of the Act, as amended by sections 4414 and 4416 of Public Law 105–33, we established two different target limits on payments to excluded hospitals, depending upon when the facilities were established. The target amount limit for excluded hospitals or units established before October 1, 1997 was set at the 75th percentile of the target amounts of similarly classified hospitals, as specified in § 413.40(c)(4)(iii), for cost reporting periods ending during FY 1996, as updated to the applicable cost reporting period. For excluded hospitals and units established on or after October 1, 1997, under section 4416 of Public Law 105–33, the payment amount for the hospital's first two 12-month cost reporting periods, as specified at § 413.40(f)(2)(ii), may not exceed 110 percent of the national median of target amounts of similarly classified hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payment.

Because we were concerned that a number of pre-1997 excluded hospitals, governed by § 413.40(c)(4)(iii), would seek to create satellite arrangements in order to avoid the effect of the lower payment caps that would apply to new hospitals under § 413.40(f)(2)(ii), we established rules regarding the exclusion of and payments to satellites of existing facilities. If the number of beds in the hospital or unit (including both the base hospital or unit and the satellite location) exceeds the number of State-licensed and Medicare-certified beds in the hospital or unit on the last day of the hospital's or unit's last cost reporting period beginning before October 1, 1997, the facility would be paid under the acute care hospital inpatient DRG system. Therefore, while an excluded hospital or unit could ''transfer'' bed capacity from a base facility to a satellite, if it increased total bed capacity beyond the level it had in the most recent cost reporting period before October 1, 1997 (see 64 FR 41532–41533, July 30, 1999), the hospital will not be paid as a hospital excluded from the acute care hospital inpatient prospective payment system. However, no similar limitation was imposed with respect to the number of total beds in excluded hospitals and units and satellite facilities of those excluded hospitals and units established after October 1, 1997, since those excluded hospitals and units were already subject to the lower payment limits of section 4416 of Public Law 105–33, and would, therefore, not benefit from the higher cap by creating a satellite facility.

Section 123 of Public Law 106–113 confers broad authority on the Secretary regarding the implementation of the prospective payment system for LTCHs, and as described in section X.N. of this final rule, we will transition the LTCH prospective payment system over 5 years. During this period, payments to LTCHs will gradually change from a blend of hospital-specific reasonable cost-based payments and the Federal rate to a fully 100 percent Federal per-discharge LTC–DRG-based prospective payment system. In addition, IRFs also will be transitioned to 100 percent fully Federal prospective payment system payment starting with cost reporting periods beginning during FY 2003. In the proposed rule, we stated that we would consider whether to propose elimination of the bed-number criteria in § 412.22(h)(2)(i) for pre-1997 hospitals, once the applicable prospective payment system is fully phased in. All LTCHs would be paid based on 100 percent of the LTCH Federal rate by FY 2007 and the payment rates established under the TEFRA system at that time will no longer exist for this class of hospitals. In addition, we noted that, starting with cost reporting periods that begin during FY 2003, payment to IRFs are no longer cost based. We also noted that any policy change for lifting the bed-number criteria for hospitals under the LTCH or IRF prospective payment systems that we consider to propose would not apply while hospitals continue to be paid under the TEFRA system. Therefore, in the proposed rule, we stated that during the 5-year phasein period, the policies in § 412.22(h)(2)(i) would continue to apply to LTCH satellites facilities.

Comment: One commenter endorsed the policy that we may limit criterion for LTCHs with satellites once the LTCH prospective payment system is fully phased in by FY 2007. Under that existing policy, we limit a LTCH with a satellite to the number of beds that does not exceed the total number of beds the hospital was licensed to have on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

Ten other commenters urged us to adopt a policy eliminating the bed-number restrictions for satellites established by pre-1997 LTCHs as soon as a LTCH elects to be paid based on 100 percent of the standard Federal rate. The commenters recommended not waiting to eliminate the bed limit until FY 2007. The commenters explained that the rationale for the policies regarding bed limits for LTCHs with satellites was established subsequent to the enactment of the BBA in 1997, which set different target amount limits for each group. The commenters believed the policy should be obsolete once a LTCH is paid 100 percent under the fully Federal rate. Two of these commenters, while agreeing that we should adopt regulations eliminating the bed limits for pre-1997 LTCHs that elect to be paid based on 100 percent of the Federal rate, suggested limiting any proposal to those situations when the LTCH's TEFRA payment rate is lower than the most recent cap under § 413.40(f)(2)(ii).

Response: We agree that it may be appropriate to propose an elimination of the bed restriction prior to all hospitals transition to the LTCH prospective payment system. Although, in the proposed rule, we indicated that we would consider proposing a change to the existing bed-limit criterion in § 412.22(h)(2)(i) for pre-1997 LTCHs once the LTCH prospective payment system was fully phased in, we agree with the argument presented by the commenters that it may be appropriate to propose dispensing with bed-number restrictions for those pre-1997 LTCHs that elect to be paid under 100 percent of the Federal rate, at the start of the cost reporting period when this election is made. The rationale for the bed limit provision at § 412.22(h)(2)(i) was the potential for gaming by creating a satellite location with a higher TEFRA target amount cap, where in reality the satellite would have been a separately certified LTCH but would have been subject to the lower cap on payments.

Once the hospital is paid under 100 percent of the prospective payment system rate, there is no longer a reason for the hospital to create a new hospital as a satellite since such a creation would not affect the hospital's prospective payment system payment. Accordingly, we will address a change in the policy concerning bed limits in the next update of the LTCH prospective payment system. Since the bed-restriction provisions on LTCHs with satellites were applicable under the TEFRA payment system, those LTCHs that are transitioning into full prospective payment and that, therefore, are still receiving a percentage of their payments under TEFRA rules, we believe, should continue to be subject to these restrictions during the phasein.

Finally, we do not believe that it may be appropriate to propose the more restrictive option suggested by the two commenters. Allowing only those hospitals with TEFRA target amounts that are below the BBA cap or the target amount to exceed the limit is not consistent with our original basis for the limit. Once a hospital is not subject to the BBA cap on the target amount, the limit should be lifted with no consideration of the comparison of the hospital's cost to its target amount.

Comment: Several commenters urged us to consider dispensing with the satellite bed-number restrictions for IRFs once the IRF prospective payment system is fully phased in for cost reporting periods beginning during FY 2003.

Response: We appreciate the comments on this issue. This area is currently under our review and may be addressed in the future when changes to the IRF prospective payment system are addressed.

Comment: One commenter suggested that, under the LTCH prospective payment system, satellite facilities should not have to independently comply with the 25-day average length of stay requirements separate from the parent LTCH.

Response: We disagree with the commenter's suggestion and are not revising the regulations that require a satellite facility of a LTCH to independently meet the average 25-day length of stay requirement under § 412.22(h)(2)(ii)(D). In establishing regulations for satellite facilities of excluded hospitals in the July 30, 1999 acute care hospital inpatient prospective payment system final rule (64 FR 41534), we clarified the need to establish financial and administrative linkage between the satellite facility and the parent excluded hospital, and we required the satellite facility to comply independently with selected statutory requirements for qualifying into the category of excluded provider of the parent hospital. We were concerned that existing hospitals that were excluded from the prospective payment system were establishing new hospitals under the guise of satellite facilities in order to circumvent several Medicare payment provisions. We also wanted to safeguard against the possibility of these satellites of excluded hospitals actually functioning as a part of an acute care hospital for the financial benefit of both facilities without any consequential clinical benefit to patients who could have reasonably been treated at an acute care hospital.

We continue to believe it is essential that the satellite facility of such an excluded hospital retain the identity of the type of excluded hospital of which it is a part by separately complying with such requirements, thereby ensuring that patients hospitalized at the satellite facility would receive the appropriate specialized care for which Medicare is paying. In the case of a LTCH, we require that a satellite facility meet the 25-day average length of stay requirement independently, since we do not believe patients not requiring long-term hospital-level care should be admitted to either the LTCH or its satellite and we are concerned that, without requiring separate compliance, shorter lengths of stay at either the LTCH or its satellite could be balanced by longer stays at the other. Therefore, we will continue to separately calculate the length of stay for patients at LTCH satellite facilities to ensure that the satellite facility is actually a LTCH that warrants payments under the LTCH prospective payment system.

Comment: One commenter urged us to limit the growth of LTCH satellites by prohibiting additional LTCH satellites from being established after October 1, 2002.

Response: We do not believe that the action suggested by the commenter is warranted at this time.

2. Criteria for Exclusion of Satellite Facilities From the Hospital Inpatient Prospective Payment System Published in the August 1, 2002 Acute Care Hospital Final Rule (67 FR 49982)

In the final rule for the acute care hospital inpatient prospective payment system, published on August 1, 2002 (67 FR 49982), we included a discussion of policy changes for satellites of prospective payment system-excluded hospitals and units and revised § 412.22(h) (67 FR 50105). Effective for cost reporting periods beginning on or after October 1, 2002, a hospital or unit that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment system for any period: (1) It is not under the control of the governing body or the chief executive officer of the hospital in which it is located; and (2) it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or the chief medical officer of the hospital in which it is located. We further indicated that a number of the criteria that apply to hospitals-within-hospitals would not be applicable to satellite facilities. One example is the requirement that the cost of services that the hospital-within-a-hospital receives from the ''host'' hospital is not more than 15 percent of the hospital's inpatient operating costs would not be an appropriate criterion. This criterion would not be appropriate because the test would not only look at the costs incurred by the satellite facility but also at the costs incurred by the entire hospital, including both the satellite facility and the main hospital.

We remain concerned that a significant potential exists for co-located providers to circumvent Medicare policy. For example, an excluded hospital would not be prohibited, under current rules, from setting up one or more satellites that could be much larger than the main provider hospital, but under the rules published on August 1, 2002, do not need to meet the separateness requirements for hospitals-within-hospitals in § 412.22(e)(5). In this scenario, a small main provider (having, for example, 50 beds), which itself could be co-located with an acute hospital as a hospital-within-a-hospital, could establish a large satellite (having, for example, 200 beds). Although this activity would be equivalent to the creation of a hospital-within-a-hospital, the hospital would, under current rules, only be required to comply with the satellite regulations at § 412.22(h), not the additional requirements for hospitals-within-hospitals (see § 412.22(e)(5)). We believe such a result would defeat the purpose of the hospital-within-a-hospital and satellite rules, by leading to the creation of facilities which are not sufficiently independent of the hospitals in which they are located to qualify for separate payment.

As noted in the above discussion of hospitals-within-hospitals and satellites under the LTCH prospective payment system, we will be monitoring all aspects of onsite Medicare providers. If we see potentially abusive configurations being developed, we may consider proposing further regulations

that would provide effective safeguards against such abuse, such as requiring any satellite facility of a prospective payment system-excluded hospital that shares a building or a campus with another Medicare provider to individually meet separateness requirements substantially the same as those in § 412.22(e)(5).

I. Monitoring System

In the March 22, 2002 proposed rule, we proposed various policies that we believed would provide equitable payment for stays that reflect less than the full course of treatment and reduce the incentives for inappropriate admissions, transfers, or premature discharges of patients that are present in a discharge-based prospective payment system. We also proposed to collect and interpret data on changes in average lengths of stay under the prospective payment system for specific LTC–DRGs and the impact of these changes on the Medicare program.

We are planning to develop a monitoring system that will assist us in evaluating the LTCH prospective payment system. If our data indicate that changes might be warranted, we may revisit these issues and consider proposing revisions to these policies in the future.

Comment: One commenter stated that, in designing the LTCH prospective payment system, we compared current costs to payments under the new prospective payment system. The commenter indicated that, since these costs may be higher than necessary, it is possible that additional payments for care provided in LTCHs may not be an appropriate expenditure of Medicare funds. The commenter urged us to gather data on the following basic issues:

- Where patients who need acute long-term care are treated in areas where there are no LTCHs;
- How costs and outcomes compare for similar patients in long-term care hospitals and other settings in areas where LTCHs do not exists;
- How costs compare for hospitals with and without onsite LTCHs;
- How costs compare for onsite LTCHs and freestanding LTCHs; and
- How the presence or absence of LTCHS affects transfers to acute care hospitals and other post-acute care settings.

Response: We agree with the commenter that these areas of study are essential to our ongoing monitoring and evaluation activities for implementation of the LTCH prospective payment system. We note that the establishment of the prospective payment system for LTCHs is required by statute. The statute specifically requires that the system be budget neutral to payments under the current TEFRA system. However, as we stated earlier, we intend to develop a monitoring system that will assist us in evaluating the LTCH prospective payment system. If our data indicate that changes are warranted, we may revisit these issues and, consistent with statutory requirements, consider revising these policies in the future.

Given that the only unique requirement that distinguishes a LTCH from other hospitals is an average length of stay of greater than 25 days, we continue to be concerned about the extent to which LTCH services and patients differ from those services and patients treated in other Medicare covered settings (for example, SNFs and IRFs) and how the LTCH prospective payment system will affect the access, quality, and costs across the health care continuum. Thus, we will monitor trends in the supply and utilization of LTCHs and Medicare's costs in LTCH and relative to other Medicare providers. For example, we may conduct medical record reviews of Medicare patients to monitor changes in service use (for example, ventilator use) over a LTCH episode of care and to assess patterns in the average length of stay at the facility level. We will consider future changes to LTCH coverage and payment policy based upon the results of such analyses.

J. Payment Adjustments

As indicated earlier, the Secretary generally has broad authority under section 123 of Public Law 106–113 in developing the prospective payment system for LTCHs. Thus, the Secretary has discretion to determine whether (and how) to make adjustments to the prospective payments to LTCHs. Section 307(b) of Public Law 106–554 directs the Secretary to ''examine'' appropriate adjustments to the prospective payments to LTCHs, including certain specific adjustments, but under that section the Secretary continues to have discretion as to whether to provide for adjustments.

In determining whether to include specific payment adjustments under the prospective payment system for LTCHs, 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, geographic location, and medical education programs. The appropriateness of potential payment adjustments is based on both cost effects estimated by regression analysis and other factors, including simulated payments that we discuss later in this section of the preamble.

Our analyses in the proposed rule were based on data from 222 LTCHs for which both costs from the cost reports in HCRIS and case-mix data from the MedPAR file were available. For this final rule, we collected costs from the cost reports and case-mix data from the MedPAR file on 198 LTCHs. We excluded LTCHs that are all-inclusive providers and providers reimbursed in accordance with demonstration projects (section X.K.2.a. of this preamble). We estimated costs for each case by multiplying hospital-specific cost-to-charge ratios by the LTCH's charges for that case. Cost-to-charge ratios were determined by obtaining costs from FY 1998 or FY 1999 cost report data, or both, as available in the HCRIS minimum data set, and charges from the Medicare claims data available in the MedPAR file. Because the universe of LTCHs has grown relatively rapidly over the last several years, in order to maximize the number of LTCHs in the database, we used the most recent cost report data available for each LTCH. If we had both FY 1998 and FY 1999 cost report data, we used the most complete cost reporting period (that is, the cost reporting period with the greater number of months). If we used FY 1998 cost report data because FY 1999 data were either unavailable (due to the time lag in cost report settlement) or incomplete, we updated the FY 1998 data for inflation using the FY 1999 excluded hospital market basket increase (2.4 percent) as published in the July 31, 1998 acute care hospital inpatient prospective payment system FY 1999 final rule (63 FR 40954). As indicated in Appendix A of this final rule, we are using the excluded hospital market basket with a capital component to update payment rates. The excluded hospital market basket is currently used to update LTCHs' target amounts for inflation under the TEFRA system. We believe that the use of the excluded hospital market basket to update LTCHs' costs for inflation is appropriate because the excluded hospital market basket measures price increases of the services furnished by excluded hospitals, including LTCHs. We believe that there is insufficient data to develop a market basket based only on LTCH costs at this time.

As we explained in the proposed rule, in computing hospital-specific cost-to-charge ratios, we matched the costs for which we had the most recent and

complete cost reporting period data to the claims in the MedPAR file for each month in that cost reporting period.

Comment: One commenter believed that a rural adjustment is an important component of the LTCH prospective payment system; the IRF prospective payment system provides for a 19.4 percent payment adjustment for rural hospitals and units. In the absence of a rural adjustment, the commenter believed that those LTCHs located in rural areas will be placed at a competitive disadvantage in the purchasing of hospital services and medical supplies since they share the labor market with rehabilitation hospitals.

Response: As we explained in the proposed rule, while our data did identify 14 rural LTCHs, the analysis of the data associated with these rural providers did not support a payment adjustment for LTCHs located in rural areas.

Therefore, under the proposed LTCH prospective payment system, all LTCHs would be treated the same for the purposes of payment, regardless of location. With regard to the 14 rural LTCHs, in the proposed rule, we compared the hospital's projected payments to both their projected costs and to what TEFRA payments would be and determined a proposed LTCH prospective payment system payment-to-cost ratio of 1.1337 and a proposed new LTCH prospective payment system payment-to-current TEFRA payment ratio of 1.2327 for those hospitals. These ratios showed that the prospective payments under the proposed LTCH prospective payment system for rural hospitals were expected to exceed their costs by 13.37 percent and exceed their payments under the TEFRA system by 23.27 percent. In this final rule, based on updated data and including the policy changes discussed above, rural hospitals are still projected to have positive ratios; for example, a new LTCH prospective payment system payment-to-current TEFRA payment ratio of 1.0796 and a new LTCH prospective payment system payment-to-cost ratio of 1.0333 (based on estimated TEFRA payments and case-mix data that were available from the MedPAR file for 194 LTCHs). Therefore, we believe the data continue to support our position that a rural location adjustment is not warranted at this time. We also point out that this was not the case for rehabilitation facilities. The regression data for IRFs showed a basis for recognizing additional costs at rural locations. Thus, under the IRF prospective payment system, there was a need for some type of adjustment for rural location.

Comment: One commenter supported our assessment that because of the low number of rural LTCHs (5 percent of the total universe) and the modest volume of patients treated in these facilities, there should not be a rural location adjustment.

Response: We appreciate the commenter's support of our position on this issue. However, we note that our policy was not based on the number of rural LTCHs or the volume of patients. Rather, the policy decision not to include a rural adjustment in the LTCH prospective payment system is based on a regression analysis of data from rural hospitals, which did not show that an adjustment is appropriate.

Comment: One commenter asked whether the cost-to-charge ratios that appear in the ratesetting file on the CMS website were adjusted for inflation.

Response: We did not apply an inflation factor to the cost-to-charge ratios since both costs and charges were taken from the same year's data (for example, FY 1999). Since we would use the same inflation factor for both the numerator (costs) and denominator (charges), the resulting ratio with the inflation factor applied would be equal to the ratio without the application of the inflation factor. Therefore, an inflation factor is unnecessary. In determining the cost-to-charge ratios, costs were taken directly from the MedPAR file.

Comment: One commenter asked why cost-to-charge ratios greater than ''2'' were in the calculation of payment amounts.

Response: We believe that the cost-to-charge ratios greater than ''2'' are legitimate and, thus, we did not believe it was appropriate to exclude them.

Comment: One commenter noted that cost-to-charge ratios are defined as the ''ratio of costs to charges from total cost report data in HCRIS matching charge data from the MedPAR files,'' and asked if this meant that a ratio of costs from the cost report to charges from the MedPAR file was used to determine the cost-to-charge ratio or if this meant that the cost-to-charge ratios appearing in the cost reports were applied to charges in the MedPAR file. If the latter method was used, the commenter wanted to know how the cost-to-charge ratios were calculated from the cost report data.

Response: A ratio of costs from the cost report to charges from the MedPAR file was created to determine the cost-to-charge ratio. The cost-to-charge ratios were determined by dividing the average cost per case from the LTCH's most recent available cost report by the LTCH's average covered charge per case from corresponding MedPAR data for the same months as the months covered by the cost reporting period. For example, for a LTCH with a 12-month cost reporting period beginning on July 1, 1999 and ending on June 30, 2000, we used MedPAR data for claims discharged from July 1999 through June 2000 to compute its cost-to-charge ratio. The cost per case for each hospital is calculated by summing all costs and dividing by the number of corresponding cases.

Multivariate regression analysis is the standard statistical technique for examining cost variation that was used to analyze potential payment adjustments for LTCHs. We looked at two standard models—(1) a double log regression explanatory model to examine the impact of all relevant factors that might potentially affect a LTCH's cost per case; and (2) a payment model that examines the impacts of those factors that were determined to affect costs and, therefore, were used to determine payment rates. In multivariate regression, the estimated average cost per case (the dependent variable) at the LTCH can be explained or predicted by several independent variables, including the case-mix index, the wage index for the LTCH, and a vector of additional explanatory variables that may affect a LTCH's cost per case, such as a teaching program or the proportion of low-income patients. The case-mix index is the average of the LTC–DRG weights, derived by the hospital-specific relative value method, for each LTCH. Short-stay outlier cases are weighted based on the ratio of the length of stay for the short-stay case to the average length of stay for nonshort-stay cases in that LTC–DRG. We simulated payments using an estimated budget-neutral payment rate and the regression coefficients as proxies for payment system adjustments. Then we calculated payment-to-cost ratios for different classes of hospitals for specific combinations of payment policies.

We examined payment variables applicable to the hospital inpatient and IRF prospective payment systems, including the disproportionate share patient percentage, both the resident-to-average daily census ratio and the resident-to-bed ratio teaching variables, and variables that account for location in a rural or large urban area. A discussion of the major payment variables and our findings appears below.

1. Area Wage Adjustment

Section 307(b) of Public Law 106–554 requires that we examine the

appropriateness of an area wage adjustment. Such an adjustment would account for area differences in hospital wage levels and would be made by adjusting the LTCH prospective payment system payment rate by a factor that will reflect the relative hospital wage level in the geographic area of the hospital, as compared to the national average hospital wage level. In the March 22, 2002 proposed rule, we did not propose implementing an area wage adjustment for payments to LTCHs because our regression analysis indicated at that time that a wage adjustment would not increase the accuracy of payments. However, as discussed below, based on the comments we received, we have reconsidered the appropriateness of including an area wage adjustment in the LTCH prospective payment system. Under the acute care hospital inpatient prospective payment system, a wage index is applied to the labor-related share of the operating standardized amount to adjust for local cost variation. The hospital wage data are used also to make an area wage adjustment under the IRF prospective payment system, the SNF prospective payment system, the home health prospective payment system, and the outpatient hospital prospective payment system.

As we discussed in the March 22, 2002 proposed rule, we analyzed the appropriateness of an area wage adjustment for LTCHs by evaluating the labor-related share from the excluded hospital with capital market basket. (This is the same market basket that is used in the IRF prospective payment system.) Currently, under the TEFRA reasonable cost-based reimbursement system, the excluded hospital market basket is used to update the cap on LTCHs' target amounts, which are used to determine payments to LTCHs for inpatient operating costs. Since we proposed to implement a single standard Federal rate under the LTCH prospective payment system (section X.K. of this preamble), we used a market basket with a capital component. A further explanation of the excluded hospital with capital market basket can be found in Appendix A of this final rule.

The labor-related share is the relative importance of wages, fringe benefits, professional fees, postal services, labor-intensive services, and a portion of the capital share for FY 2003. We determined a labor-related share of the excluded hospital with capital market basket by first estimating the portion related to operating costs. The excluded hospital with capital market basket is based on available cost data for facilities excluded from the acute care hospital inpatient prospective payment system, including long-term care, rehabilitation, psychiatric, cancer, and children's hospitals.

In the proposed rule, we determined a labor-related share of the excluded hospital with capital market basket by first estimating the portion related to operating costs. Using the excluded hospital with capital market basket, we determined the labor-related share of operating costs to be 69.428 percent for FY 2003, which is calculated as the sum of the relative importance for wages and salaries (50.381 percent), employee benefits (11.525), professional fees (2.059), postal services (0.244), and all other labor intensive services (5.219).

The labor-related share of capital costs in the market basket needed to be considered as well. We used the portion of capital attributed to labor, which our Office of the Actuary estimated on the basis of cumulative knowledge of prospective payment systems, to be 46 percent. This was the same percentage used for both the acute care hospital inpatient capital prospective payment system and the IRF prospective payment system. In the proposed rule for FY 2003, we estimated, based on the historical knowledge of prospective payment systems, the relative importance for capital to be 7.552 percent of the excluded hospital with capital market basket. We then multiplied 46 percent by 7.552 percent to determine that the labor-related share for capital costs for FY 2003 to be 3.474 percent. We then added the 3.474 percent for capital costs to the 69.428 percent for operating costs to determine the total labor-related share based on the excluded hospital with capital market basket. Thus, in the proposed rule, when we examined an adjustment to account for area differences in hospital wage levels, we used a labor-related share of 72.902 percent for the LTCH prospective payment system.

Based on updated data, for this final rule we estimate the relative importance for capital for FY 2003 to be 7.515 percent of the excluded hospital with capital market basket. We then, for this final rule, multiplied 46 percent by 7.515 percent to determine that the labor-related share for capital costs for FY 2003 to be 3.457 percent. Accordingly, based on updated data for FY 2003, the labor-related share of the excluded hospital with capital market basket is 72.885 percent (69.428 plus 3.457).

Specifically, in the proposed rule, we examined the appropriateness of accounting for differences in area wage levels by multiplying the labor-related share of the unadjusted Federal payment by the FY 2002 inpatient acute care hospital wage index, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. (This methodology is the same as the methodology used under the IRF prospective payment system and the SNF prospective payment system.) For purposes of both the proposed rule and the final rule, wage data to compute LTCH-specific wage indices were not available. However, LTCHs and other postacute care facilities (for example, IRFs, SNFs, and HHAs) generally compete in the same local labor market for the same types of employees as inpatient acute care hospitals.

Comment: Several commenters recommended that we develop a wage index based on LTCH data. One commenter suggested that if LTCH wage data are unavailable due to the lack of Worksheet S–3 data, other means could be utilized in the short term to create a labor adjustment mechanism. Alternatively, the commenter suggested that the wage indices used for the acute care hospital inpatient prospective payment system could be weighted to account only for those wage areas containing a LTCH.

One commenter suggested that the payments under the LTCH prospective payment system should be adjusted using the current inpatient acute care hospital wage indices, but a different labor-related share should be chosen to reflect the experience of LTCHs. Another commenter recommended establishing a LTCH wage index using the labor share estimated by the excluded hospital market basket and the wage indices used in the IRF prospective payment system.

Response: At this time, we are unable to develop a separate wage index for LTCHs based solely on LTCH data. Currently, there is a lack of specific LTCH wage and staffing data necessary to develop a separate LTCH wage index accurately. As we stated in the proposed rule, in order to accumulate the data needed for such an effort, we would need to make modifications to the Medicare hospital cost report. Because we do not have LTCH specific wage data, at this time we are unable to determine an appropriate weighting factor for the acute care wage index to account only for those wage areas containing a LTCH. In the future, we will continue to research the appropriateness of the acute care hospital wage index for LTCHs and may investigate the feasibility of developing a wage index specific to LTCHs. However, at this time, we believe that the wage index based on acute care

hospital wage data contains the best and most appropriate data to use, and it is the same wage index used in the prospective payment system for other postacute care for providers (IRFs, SNFs, and HHAs). Therefore, we believe the acute care hospital wage index for FY 2003 is appropriate since LTCHs and other postacute care facilities generally compete in the same local labor market for the same types of employees as inpatient acute care hospitals.

In addition, we believe that the labor-related share, which is based on the excluded hospital with capital market basket, appropriately reflects the experience of LTCHs since it is based on available cost data for facilities excluded from the acute care hospital inpatient prospective payment system, including long-term care, rehabilitation, psychiatric, cancer, and children's hospitals.

Comment: Many commenters expressed concern that no area wage adjustment was provided for in the LTCH prospective payment system. Specifically, they noted the following issues: (1) LTCHs in high wage areas will have difficulty competing in labor markets with other providers whose payments are wage adjusted; (2) LTCHs in high wage areas will have difficulty in recruiting staff with the appropriate skill mixes; and (3) services in high wage areas will need to be cut to meet fixed LTCH prospective payment system payments that are not adjusted to account for differences in area wages. Given these concerns, one commenter submitted findings by The Lewin Group regarding the regression analysis on a wage adjustment for LTCHs.

The Lewin Group performed an analysis which showed that by removing from the sample one LTCH that has high volume and very low cost per case, the wage index is shown to have a positive and statistically significant impact on overall costs (the wage index coefficient was found to be 18.8 percent, which is approximately 25 percent of the full labor-cost share). Therefore, the commenter believed it is appropriate to include the area wage adjustment in a 5-year transition period. The commenter also suggested that if we are not inclined to include an area wage adjustment, an alternative would be to use a modified area wage index adjustment that have ''soft'' upper and lower wage adjustment limits to lessen the gains and losses that otherwise might occur.

Another commenter stated that based on the analysis by The Lewin Group, the statistical results found by us may be influenced by a small number of extreme values from a few hospitals that unduly influenced the statistical models. Other commenters asserted that the sample of LTCHs used by us is not statistically valid for determining whether a wage adjustment is appropriate. One commenter pointed out that the ratesetting file used by us consisted of 20 percent of the LTCHs being located in Texas and 10 percent located in Louisiana. The commenter believed that, since these two States typically have lower wages than the rest of the country, by not incorporating a wage adjustment, we are inappropriately reimbursing providers across all States and failing to take into account the evidence before it.

One commenter claimed that as it is obvious the data or the statistical analysis, or both, used by us are not accurate or appropriate for the sample of LTCHs used, it is not reasonable to conclude that LTCHs have a labor-related share of cost of only 19.91 percent. The commenter cited Tables 7 and 8 of the Health Care Financing Administration Review/Winter 2001, which show the cost of routine nursing care (including bed and board) as representing an average 66 percent of costs of the LTCHs. Another commenter stated that even though the results of our regression model do not support a wage adjustment, there is empirical data compiled by the Bureau of Labor Statistics that clearly identified the wide variability of wages across the country. Several other commenters asserted that allowing a wage adjustment for other providers, but not LTCHs, based on statistical accuracy from a past time period, is poor public policy and this policy could lead to destabilization of payments rates and should be avoided.

One commenter stated that our belief that an area wage index adjustment as a component of a LTCH prospective payment system does not improve the statistical accuracy of the payment is counter intuitive, fails to address concerns that inadequate financing of labor costs will adversely affect patient care, and fails to address a statement made by MedPAC staff that the quality of LTCH data may have an effect on analysis of this issue.

Several commenters also cited MedPAC's June 2001 Report to Congress, in which it states that ''the objective of the geographic adjustment is to make Medicare's payment rates accurately reflect the costs efficient providers would incur in furnishing services to beneficiaries given local market wages.'' In that same report, MedPAC also stated that without a geographic wage adjustment, Medicare's payment rates would be too high in labor markets with relatively low wage rates and providers would face incentives to furnish too many services, while Medicare's payment rates would be too low in labor markets with relatively high wage rates, ''giving providers financial incentives to produce too few services, stint on services or inputs (especially labor), or cease participating in Medicare.''

Other commenters pointed out that numerous older LTCHs, located primarily in high wage areas, have been constrained by their TEFRA target amounts and have been more vigilant in reigning in their expenses. Another commenter speculated that if the average cost per case in LTCHs did not vary with the wage index, the data were unreliable or there is a wide heterogeneity among services. The commenter believed that service heterogeneity is significant because newer facilities have not been subject to the same cost limits as older facilities, and there is a large mix of old and new facilities in the LTCH sector. Furthermore, the commenter explained that, historically, older facilities tend to be located in the northeastern region of the country where the cost of labor is higher on average than in other areas of the country. Therefore, the historical effect of the TEFRA caps may be obscuring the effect of regional differences in wage levels in the empirical model. The commenter added that, moreover, the theory of prospective payment systems is that the national rate is intended to cover a set of clinically similar services. Given that wage levels have proven to vary regionally, by not providing a wage adjustment, the policy gives the national average rate less purchasing power in high labor cost regions of the country, thus diminishing the level of care available to LTCH Medicare beneficiaries in those areas.

Other commenters expressed concern that since, at present, approximately 33 percent of LTCHs are geographically clustered in three States (Texas, Louisiana, and Massachusetts), it would appear that a prospective payment system with no wage adjustment would encourage further clustering of LTCHs. Another commenter also noted that the negative statistical finding could perpetuate acknowledged distortions of the TEFRA payment system. Thus, a wage adjustment for high wage areas would be appropriate.

With respect to our assertion that including a wage adjustment would inappropriately redistribute payments to LTCHs by shifting reimbursement to LTCHs that are located in an area within a higher wage index, but in fact, with lower costs, one commenter stated that

we need to recognize and reward these efficient providers, which would be consistent with the objectives of the proposed prospective payment system for LTCHs, that is, ''to provide incentives to control costs and to furnish services as efficiently as possible.''

Response: In examining the comments and suggestions we received, several issues led us to reconsider our previous decision. First, we agree with the commenters that there is a possibility that TEFRA policies may have in some way affected the relationship between LTCHs' geographic location and costs. As was pointed out by several commenters, older LTCHs with relatively low TEFRA ceilings are often located in large urban areas, which may provide an explanation for the results of our statistical analysis. In addition, the historical effect of the TEFRA caps may be affecting the expected effect of regional differences in wage levels of LTCHs operating under the prospective payment system. We also agree with many of the commenters' concerns that, by providing for a wage adjustment, LTCHs in high wage areas may help ensure that these LTCHs can compete in labor markets with other providers whose payments are wage adjusted; can recruit appropriate staff; and can deliver sufficient high quality services to Medicare beneficiaries.

As to the sensitivity analysis that was conducted, we agree with commenters that it is reasonable to expect that a hospital's wage costs will affect total costs and that, in consequence, the payment amounts under the new system should be adjusted using a wage index. However, the statistical analysis presented by one commenter included analysis where the effect of wages, though small, was positive and significant, as well as other models where the effect was small and negative, but also significant. This indicates that the regression estimates are very sensitive to the inclusion and exclusion of certain facilities. Unfortunately, this limits our ability to base policy on the results of the commenter.

We believe that it is reasonable to assume that wages have an effect on case-mix adjusted LTCH costs. However, we believe that these inconsistent results may be due to limitations in the current data from the LTCHs. This is not surprising because case-mix information has not been previously used for payment for these hospitals, and since various LTCHs have been subject to varying TEFRA limits. Despite the results of the commenter's statistical analysis, we have reconsidered our proposal not to include a wage adjustment and now believe that the conceptual reasons for having an area wage adjustment support transitioning into a wage adjustment, notwithstanding the data problems and issues with the regression analysis. We reevaluated the statistical analysis presented in the proposed rule along with our most recent findings based on the latest available data. Based on the results of this reevaluation, we now agree with the commenter's suggestion that it is appropriate to phase-in a wage adjustment over a transition period.

In the proposed rule, we analyzed the results of the wage index coefficient derived from regression analysis to validate the labor-related share calculated from the market basket. In the regression, we standardized each LTCH's cost per case by the various factors, such as case-mix, bed size, number of cases, length of stay, and occupancy. The wage index coefficient allowed us to approximate the labor-related portion of cost per case. Since the labor-related share derived from the market basket is the proportion of costs that have been identified as being influenced by the local labor amount, we expected this coefficient to be statistically significant and near our market basket measure. The double-log regression analysis in the proposed rule generated a wage index coefficient, which approximated the labor-related portion of cost per case, that was not near the market basket measure (72.902 percent). For this final rule, based on updated data we reran the regression, and the double log regression continues to show a wage index coefficient for the market basket, which at most is approximately 20 percent.

While the statistical analysis did not show a significant relationship between LTCHs' costs and their geographic location, we believe it is appropriate to include some adjustment for area wages. Accordingly, we will incorporate a wage index adjustment, but beginning with FY 2003, as one commenter suggested, we will transition to a full wage adjustment over a 5-year period. Accordingly, for the first year of the LTCH prospective payment system, the area wage adjustment will be one-fifth of the full FY 2002 wage index without geographic reclassifications. We will continue to reevaluate LTCH data as they become available and would propose to adjust the phasein if subsequent data support a change. Therefore, we are amending § 412.525 to add a new paragraph (c), which provides for an appropriate adjustment to the labor-related share of the unadjusted LTCH Federal rate.

As we described in the proposed rule and as several commenters supported, we are establishing a LTCH wage index using the labor-related share estimated by the excluded hospital market basket with capital and the wage indices computed from data from inpatient acute care hospital wage data without regard to reclassifications under sections 1886(d)(8) or 1886(d)(10) of the Act. This is consistent with the area wage adjustments under the prospective payment systems for other postacute care providers (IRFs, SNFs, and HHAs).

As discussed above, to calculate wage adjusted payments for the payment rates set forth in this final rule, the prospectively determined unadjusted LTCH Federal rate is multiplied by the labor-related percentage (72.902) to determine the labor-related share of LTCH Federal rate. The labor-related share is then multiplied by the applicable LTCH wage index as shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum of this final rule. For FY 2003, the applicable LTCH wage index will be one-fifth (the first year's proportionate fraction of a 5-year phasein) of the full FY 2002 inpatient acute care hospital wage index, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. (See section X.J.2. of this preamble regarding geographic reclassification.) The resulting wage-adjusted labor-related share is then added to the nonlabor-related share (27.098 percent), resulting in a wage adjusted payment rate. The following example illustrates how the wage-adjusted LTCH Federal rate would be computed for a LTCH located in Chicago, IL (MSA 1600) with a hypothetical LTCH unadjusted Federal rate of $10,000. The FY 2003 one-fifth LTCH wage index value for MSA 1600 is 1.0202. The labor-related share (72.885 percent) of the hypothetical LTCH Federal rate is $7,288.50 ($10,000 $\times$ 0.72885) and the nonlabor-related share (27.115 percent) is $2,711.50 ($10,000 $\times$ 0.27115). Therefore, the wage-adjusted LTCH payment rate is: $10,147.23 = ($7,288.50 $\times$ 1.0202) + $2,711.50.

For FY 2003, the applicable LTCH wage index for LTCHs located in urban areas and for LTCHs located in rural areas are shown in Tables 1 and 2, respectively, in the Addendum to this final rule.

Comment: MedPAC examined two possible reasons why we found that the differences in local input prices were not significant predicators of costs for care in LTCHs: high correlation of patient need with local wages and a lack

of variation in wages for locations. It found ''the correlation of patient need and wages to be low'' and that ''the wages for counties where LTCHs are located did vary widely.'' MedPAC also hypothesized that limitations on increases in costs imposed by the TEFRA payment system could have distorted costs; however, it was unable to test this third possibility. MedPAC expressed concern that if we do not adjust rates for local input prices, ''hospitals with low wages may be overpaid and those with high wages may be underpaid.'' However, MedPAC also contended that ''if CMS does adjust to account for differences in wages, the opposite error may result.'' In conclusion, MedPAC stated that the need for a wage adjustment should be reexamined when better data are available.

Three additional commenters agreed with our proposal not to include an adjustment for area wages until better data are available. One commenter agreed that there should not be an area wage adjustment for payment to LTCHs because there is not a significant distinction between the LTCHs' costs and their geographic location. Another commenter also agreed that there should not be an area wage adjustment at this time, stating that the decision should be made based on LTCH data rather than an assertion that all payment systems need to include the same components. The same commenter added that until the LTCH data support a change in the policy, the proposed position not to include a wage adjustment should be maintained.

Response: We appreciate the commenters' support of our proposal to delay implementing the wage adjustment. However, as discussed above, we have reconsidered our position and are phasing in a wage index over a 5-year period.

2. Adjustment for Geographic Reclassification

In accordance with section 307(b) of Public Law 106–554, we also examined the appropriateness of applying an adjustment for geographic reclassification to payments under the LTCH prospective payment system, where hospitals could request reclassification from one geographic location to another for the purpose of using the other area's wage index value, Federal payment rates, or both. A similar adjustment is available under the acute care hospital inpatient prospective payment system in accordance with section 1886(d)(10) of the Act. The adjustment would treat a hospital located in one geographic area as being located in another geographic area, if certain conditions are met. As explained below, at this time, we are not implementing an adjustment for geographic reclassification in the prospective payment system for LTCHs.

In the March 22, 2002 proposed rule, we indicated that our data identified 14 rural LTCHs, but our analysis supported neither an adjustment to account for differences in area wage levels nor an adjustment for LTCHs located in rural areas or large urban areas because the regression analysis indicated that a wage adjustment would not increase the accuracy of payments. Therefore, under the LTCH prospective payment system, we proposed that all LTCHs would be treated the same for the purposes of payment, regardless of location. Since there would have been no purpose for LTCHs to reclassify to another area, we did not propose to implement an adjustment for geographic reclassification in the prospective payment system for LTCHs.

After publication of the March 22, 2002 proposed rule, we revisited the appropriateness of an adjustment for geographic reclassification. Under the TEFRA payment system, hospitals and units excluded from the acute care hospital inpatient prospective payment system, including LTCHs, are not required to fill out information related to wage-related costs on the Medicare cost report (Worksheet S–3). Thus, we would need to provide for the collection of pertinent wage information as well as developing some type of application and determination process before a geographic reclassification process could be implemented.

In the proposed rule, we had stated that if a wage adjustment was ultimately implemented as part of the LTCH prospective payment system, and it was determined that it was appropriate to make geographic reclassification adjustments, as we stated above, we would need to prepare instructions for data collection on LTCH wage-related costs in order to determine an appropriate geographic reclassification adjustment for LTCHs. It would also be necessary to develop an application process as well as determination procedures.

We have only included a wage index adjustment that will transition to a full adjustment over 5 years. Also, we will not be establishing a geographic reclassification process at this time. We will monitor all incoming wage-related data and will examine the appropriateness of implementing a geographic reclassification process at a later date.

Comment: One commenter supported our position of providing no adjustment for geographic reclassification in the LTCH prospective payment system. It was the commenter's position that LTCHs, regardless of location, should be treated the same for purposes of payment.

Response: While we appreciate the commenter's support of our position in this matter, as we stated in the proposed rule, we have revisited the appropriateness of an adjustment for geographic reclassification based on the latest data available. Hospitals that are currently excluded from the acute care hospital inpatient prospective payment system (that is, hospitals paid under the TEFRA payment system) are not required to provide wage-related information on the Medicare cost report (Worksheet S–3). Thus, in order to provide for an adjustment for geographic reclassification, we would first need to establish instructions for data collection on LTCH wage-related costs, and we would also need to develop an application process and determination procedures.

Also, in order to be consistent with the area wage adjustments made to other postacute care providers (that is, under the existing HHA, SNF, and IRF prospective payment systems), we are using the inpatient acute care hospital wage data without regard to any approved geographic reclassifications under section 1886(d)(8) or 1886(d)(10) of the Act. Therefore, we are not adopting the use of ''post reclassification'' wage data, and the area wage adjustment for a LTCH will be based on the provider's actual location, without regard to the urban or rural designation of any affiliated or related providers.

While we are providing for a phased-in wage adjustment for LTCHs, as we discussed above, we will be transitioning to a full wage adjustment over a 5-year period. That is, the LTCH payment rate will be adjusted, but only by one-fifth of the hospital's wage index in the first year (FY 2003). Adjustment will be phased-in in one-fifth increments to 100 percent of the wage index over the next 4 years. Considering that the effect of the adjustment for area wages will be reduced significantly for the first year and, therefore, the impact of any reclassification would be minimal, we believe the administrative burden resulting from an attempt to develop an adjustment for geographic reclassification at this time outweighs the benefits of any reclassification. However, we intend to examine the feasibility of establishing a system for geographic reclassifications as more of

the wage index in subsequent years is used to establish prospective payment system payments.

Accordingly, in this final rule, we are not providing for an adjustment for geographic reclassification in the LTCH prospective payment system. However, if we determine at a later date that a reclassification adjustment for LTCHs is warranted, we will explore the development of an appropriate reclassification process.

3. Adjustment for Disproportionate Share of Low-Income Patients

Section 307(b) of Public Law 106–554 requires that we examine the appropriateness of an adjustment for hospitals serving a disproportionate share (DSH) of low-income patients, consistent with section 1886(d)(5)(F) of the Act, which establishes this adjustment for inpatient acute care hospitals. As we discussed in the proposed rule, in assessing the appropriateness of a similar adjustment for LTCHs serving low-income patients, as specified in section 1886(d)(5)(F) of the Act, we focused our analysis on the relationship between serving low-income patients and LTCHs' cost per case. Based on the results of our analysis, we did not propose an adjustment for the treatment of a disproportionate share of low-income patients. Given the statistical analysis presented in the proposed rule (described below) and our most recent findings based on the latest available data that confirm the analysis in the proposed rule, at this time we are not implementing an adjustment for the treatment of a disproportionate share of low-income patients.

Under section 1886(d)(5)(F) of the Act, in calculating Medicare payments for inpatient services at acute care hospitals, the disproportionate share patient percentage takes into account both the percentage of Medicare patients who receive SSI and the percentage of Medicaid patients who are not entitled to Medicare. The DSH patient percentage is defined as:

$$\text{DSH Patient Percent} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

Based on this formula, an inpatient acute care hospital qualifies for a DSH adjustment under section 1886(d)(5)(F)(v) of the Act (as amended by section 211(a) of Public Law 106–554) if the hospital has a DSH patient percentage greater than or equal to 15 percent. The calculation of the DSH payment adjustments are implemented at § 412.106.

We analyzed the results of applying a DSH adjustment, in accordance with the criteria at section 1886(d)(5)(F) of the Act described above, on LTCHs. As we discussed in the proposed rule (67 FR 13467), because the LTCH prospective payment system must be budget neutral in accordance with section 123(a) of Public Law 106–113, in modeling payments we found that the inclusion of such a DSH policy would have resulted in a 3.31 percent decrease to the base payment rate. Furthermore, the inclusion of such a DSH policy would also have resulted in a 3.79 percent decrease in the r-squared value (a statistical measure of how much variation in resource use among cases is explained by the system). Accordingly, we found that including a DSH adjustment that is consistent with section 1886(d)(5)(F) of the Act would reduce the explanatory power of the LTCH prospective payment system, or the ability of the payment system model to predict cost per case, while lowering the base payment rate. Thus, we did not propose to implement a DSH adjustment consistent with section 1886(d)(5)(F) of the Act. For this final rule, based on updated data, we reevaluated the inclusion of DSH adjustment consistent with section 1886(d)(5)(F) of the Act, and our analysis based on the latest available data confirmed the analysis in the proposed rule. In fact, while for a wage index adjustment there was at least some (though small) positive and significant effect of wages on costs in the regression, this was not the case for a DSH adjustment. The regression showed no positive effect on costs. Therefore, at this time we are not implementing a DSH adjustment consistent with section 1886(d)(5)(F) of the Act.

As discussed in the proposed rule, we also evaluated an alternative adjustment, using regression analysis, that takes into account both the percentage of Medicare patients who are receiving SSI (SSI percent) and the percentage of Medicaid patients who are not entitled to Medicare (Medicare percent) without the other criteria specified in section 1886(d)(5)(F) of the Act. This analysis was made to determine if there was any relationship between these two variables and cost per case. The results of this analysis showed that the regression coefficients for both the percentage of Medicare patients who are receiving SSI and the percentage of Medicaid patients who are not entitled to Medicare would be statistically significant at the 99-percent level. However, the positive relationship between cost per case and the percentage of LTCH Medicare patients who are receiving SSI would be offset by a negative relationship between cost per case and the percentage of LTCH Medicaid patients who are not entitled to Medicare. This implied that while costs per discharge would appear to increase (slightly) as the percentage of LTCH Medicare SSI patients increases, costs per discharge would decline (slightly) as the percentage of LTCH Medicaid, non-Medicare patients increased. Therefore, we did not propose to implement an adjustment for the treatment of a disproportionate share of low-income patients based on a LTCH's combined SSI percentage and Medicaid percentage. For this final rule, based on latest available data, we reevaluated the inclusion of DSH adjustment based on a LTCH's combined SSI percentage and Medicaid percentage, and our findings confirmed the analysis in the proposed rule. Therefore, at this time we are not implementing an adjustment for the treatment of a disproportionate share of low-income patients based on a LTCH's combined SSI percentage and Medicaid percentage.

Finally, in the proposed rule, we also examined an adjustment for the treatment of low-income patients based solely on a LTCH's SSI ratio (the percentage of Medicare patients who are receiving SSI). The SSI ratio is calculated by dividing Medicare SSI days by total patient days. While the regression coefficient was positive, it was not very large (0.04), which meant that for every 1 percent increase in the SSI percent, a 0.04 percent increase in cost per case would be observed. Thus, at best, an empirically based adjustment based on the SSI percent would have been very small. Furthermore, the positive regression coefficient for the SSI percentage was significantly influenced by the large SSI percentages of only a few LTCHs. Because section 123(a) of Public Law 106–113 requires that the LTCH prospective payment system be budget neutral, applying such an adjustment under the proposed rule

would have resulted in a 2.98 percent reduction in the base payment rate for all LTCHs that was based on a small positive regression coefficient that was due mostly to a relatively small number of LTCHs with a large SSI percentage. Therefore, we did not believe it was appropriate to implement a DSH adjustment based on a LTCH's SSI percentage. Based on updated data, for this final rule, we have reexamined an adjustment for the treatment of a disproportionate share of low-income patients based on a LTCH's SSI percentage, and our analysis confirmed the results presented in the proposed rule. In fact, using the same methodology as used in the proposed rule, and using the latest available data, the regression coefficient actually decreased from .04 percent to .02 percent.

Because the analyses described above do not indicate an increase in the accuracy of payments based on the adjustments examined for the treatment of a disproportionate share of low-income patients, we are not implementing a disproportionate share adjustment in this final rule.

Comment: Commenters provided various reasons for including a DSH adjustment in the LTCH prospective payment system. One commenter asserted that the acute care hospital inpatient prospective payment system has a DSH policy although it was not significantly correlated with Medicare cost per case at implementation. Another commenter stated that the omission of a DSH adjustment is inconsistent with other Medicare-related payments (for example, acute care hospital inpatient prospective payment system and IRF prospective payment system). The commenter believed it inappropriate and inaccurate to view LTCHs differently in comparison with other types of hospitals. Several commenters explained that for the same reasons that acute care hospitals that serve a disproportionate number of Medicaid and Medicare SSI-eligible patients need additional reimbursement to compensate for the financial burden of treating patients from these populations, LTCHs being reimbursed under the prospective payment system need supplemental payments.

Another commenter expressed concern that the lack of a DSH adjustment, combined with other proposed payment policies in the LTCH prospective payment system, may create disincentives for LTCHs to admit dually eligible patients, especially those likely to exhaust their Medicare Part A benefits during their stay. One commenter noted that a DSH payment would appropriately account for high costs incurred by facilities that treat a particularly high proportion of low-income patients. It was also pointed out by a commenter that the inclusion of a DSH adjustment similar to that provided in acute care hospitals under the hospital inpatient prospective payment system would help in ensuring access to care for low-income patients in LTCHs. In addition, the absence of DSH payments, unlike other prospective payment systems that provide for such an adjustment, deprives LTCHs the opportunity for governmental participation in the cost of care for the medically indigent patient population.

Another commenter stated that even though payments directed to DSH hospitals would be diverted from base payments or other elements of payment, as a matter of social policy, additional support should be provided to DSH hospitals in recognition of the additional burden that these hospitals incur by ensuring access to care for low-income populations. Moreover, as another commenter pointed out, in the past, Congress and MedPAC have established that DSH payments are a matter of important public policy. Also, it is the responsibility of the government to make DSH payments, as it is an important feature of health care policy and should be subordinate to notions of inaccuracy.

Several commenters understood that a DSH policy had not been proposed as part of the LTCH prospective payment system because it would not increase payment accuracy, as measured by a case-based regression model. However, as one commenter pointed out, the commenters believe that the LTCH prospective payment system regression models did not show a relationship between cost and indigent care because these models had limited utility due to the legacy of the TEFRA caps on older LTCHs, based on Medicaid-eligible days.

Response: As mandated by the statute, we examined the appropriateness of an adjustment for LTCHs serving a disproportionate share of low-income patients, consistent with § 1886(d)(5)(F) of the Act (which established the DSH adjustment for acute care hospitals). Examining the most recent LTCH data available to us, we determined that an adjustment consistent with that of inpatient acute care hospitals would reduce the ability of the payment system to predict cost per case while lowering the base payment rate. Also, while the data demonstrated in both acute care hospital inpatient prospective payment system, as well as the IRF prospective payment system, support the appropriateness of a DSH payment adjustment, no such data support was forthcoming for LTCHs.

As directed by the statute, we determined whether a DSH adjustment should be established for LTCHs. To provide for a DSH adjustment for LTCHs solely because it is consistent with other prospective payment systems or appropriate in comparison with other types of hospitals, we believe is an insufficient justification for providing such an adjustment. Rather, our concern lies in whether we can equitably and fairly establish a DSH adjustment in the context of a prospective payment system designed for LTCHs. Moreover, we sincerely share the concerns of commenters with regard to seeking a means to help pay for the additional costs of those facilities that serve a large population of low-income Medicare patients. However, we also believe it is our responsibility to establish a payment system for LTCHs that would prove to be fair and equitable to providers and patients, alike.

In that regard, we have evaluated alternative methods to provide some type of DSH payment adjustment. As stated above, using regression analysis which took into account both the percentage of Medicare patients receiving SSI and the percentage of Medicaid patients not entitled to Medicare, we found no significant empirical relationship between these variables and cost per case. In addition, we examined an adjustment for the treatment of low-income Medicare patients based solely on a LTCH's SSI ratio, but that also did not show significant evidence that a DSH adjustment would be appropriate.

One commenter supposed that the LTCH prospective payment system regression models did not show a relationship between LTCH's cost per case and serving low-income patients due to the effects of the caps imposed on the older LTCHs under the TEFRA payment system. Although it may be possible that the effects of cost-based reimbursement may have affected the relationship between a LTCH's cost per case and serving low-income patients in the regression analysis, we continue to believe that the best option available at this time would be to collect and interpret new data as it becomes available, after the LTCH prospective payment system is implemented and LTCHs' costs are no longer affected by the TEFRA target amount limitation.

4. Adjustment for Indirect Teaching Costs

In accordance with the directive of section 307(b) of Public Law 106–554 to examine ''appropriate adjustments'' to payments under the LTCH prospective payment system, for the proposed and final rules, we also examined the appropriateness of applying an adjustment for indirect teaching costs to payments under the LTCH prospective payment system. Based on the analysis described below, we did not propose to implement an adjustment for indirect teaching costs.

There are presently 14 LTCHs with teaching programs. LTCHs with teaching programs tend to be older, larger (greater than 125 beds) hospitals, located in large urban areas, and have a higher proportion of low-income patients but with a lower case-mix index. As we discussed in the proposed rule (67 FR 13468), based on a double log regression, we found that the indirect teaching cost variable would be negative and not significant. We looked at different specifications for the teaching variable. We used a resident-to-bed ratio as the coefficient for the teaching variable in the regression that is currently used to measure teaching intensity under the acute care hospital inpatient prospective payment system for operating costs. We also used a ratio of residents to average daily census (defined as total inpatient days divided by the number of days in the cost reporting period) that is currently used under the acute care hospital inpatient prospective payment system for capital-related costs, as a measure of teaching intensity. We based this analysis on the estimated number of full-time equivalent (FTE) residents assigned to the inpatient area of the LTCH. In all of our payment regressions, we determined that the teaching variable would not be significant. This means that no empirical evidence exists to show that LTCHs' cost per case would vary with teaching costs.

For this final rule, based on updated data, we reexamined the appropriateness of an adjustment for indirect teaching costs using the approach described above. Our most recent findings based on the latest available data confirmed the analysis in the proposed rule that no empirical evidence exists to show that LTCHs' cost per case would vary with teaching costs.

Comment: One commenter supported our proposal to not include a payment adjustment for indirect teaching costs but requested that we review the data within 2 years and determine if an adjustment is needed at that point.

Response: We intend to evaluate data on indirect teaching costs in LTCHs as more data become available to determine if additional data support proposing any future payment adjustments.

Accordingly, in this final rule, for the same reason indicated above, we are not implementing an adjustment for indirect teaching costs.

5. Cost-of-Living Adjustment (COLA) for Alaska and Hawaii

In accordance with the directive of section 307(b) of Public Law 106–554 to examine ''appropriate adjustments'' to payments under the LTCH prospective payment system, we also examined the appropriateness of applying a cost-of-living adjustment (COLA) under the LTCH prospective payment system for LTCHs located in Alaska and Hawaii.

There is currently one LTCH in Hawaii and no LTCHs in Alaska. As we discussed in the proposed rule (67 FR 13468), in the absence of a COLA, we performed simulations, which indicate that the facility in Hawaii might experience a payment to cost ratio of 0.89 percent. In this final rule, using updated data, we performed simulations and again found that the payment to cost ratio is approximately .90 percent. Therefore, as we proposed, we are implementing a COLA for LTCHs in Hawaii and Alaska to account for the higher costs incurred in those States.

As we explained in the proposed rule, the IRF proposed rule (November 3, 2000, 65 FR 66357) indicated that based on payment simulations, without a COLA, the one IRF located in Alaska may have a loss and the one IRF for which data were available would have a gain. Due to the small number of cases, analysis of the simulation results for IRFs were inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Accordingly, we did not include a COLA adjustment for those hospitals in the prospective payment system for IRFs (65 FR 66357, November 3, 2000). We believe it appropriate, however, to implement a COLA for LTCHs based on the higher costs found in Hawaii. In general, the COLA would account for the higher costs in the LTCH and will eliminate the projected loss that the LTCH in Hawaii will experience absent the COLA. Furthermore, this policy is consistent with the COLA made to account for the higher costs in acute care hospitals in Alaska and Hawaii under both the operating prospective payment system and the capital prospective payment system. We will make a COLA, under § 412.525(b), to payments for LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the appropriate factor listed in the table below. These factors are obtained from the U.S. Office of Personnel Management.

COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS

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

We received one comment in support of providing a COLA to payments for LTCHs located in Alaska and Hawaii. For the reasons noted above, we are implementing a cost-of-living adjustment to payments for LTCHs located in Alaska and Hawaii, as described above, in this final rule.

6. Adjustment for High-Cost Outliers

In accordance with the directive of section 307(b) of Public Law 106–554, we also examined the appropriateness of an adjustment for additional payments for outlier cases. These are cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers could strongly improve the accuracy of the LTCH prospective payment system in determining resource costs at the patient and hospital level. These additional payments would reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, would reduce the incentives to underserve these patients.

In the March 22, 2002 proposed rule (67 FR 13468), we discussed and considered various outlier policy options. Specifically, we considered outlier policies under which outlier payments would be projected to be 5 percent, 8 percent, or 10 percent of total LTCH prospective payment system payments. We considered the impact of setting the outlier target percentage at 5 percent because that percentage is consistent with the range of targets provided under section 1886(d)(5)(A)(iv) of the Act for the acute care hospital inpatient prospective payment system. We also considered an outlier target of 10 percent because that percentage was recommended in an

industry study commissioned by NALTH. In addition, we considered an outlier target of 8 percent to analyze the impact of setting the outlier target at some percentage between 5 and 10 percent.

In the proposed rule, we also examined marginal cost factors, or the change in total cost with one unit of change in output, of 55 and 80 percent. We examined an 80-percent marginal cost factor for outlier payments because it is the same as the factor used under both the acute care hospital inpatient prospective payment system and the IRF prospective payment system. We also examined a 55-percent marginal cost factor in order to analyze the impact that a lower marginal cost factor would have on outlier payments and payments for all other cases.

As discussed in further detail in the June 4, 1992 acute care hospital inpatient prospective payment system proposed rule (57 FR 23640), a study performed by RAND Corporation indicated that the marginal cost of care is usually less than the average cost because later days of a stay have considerably lower costs than the earlier days of the stay.

In order to determine the most appropriate outlier policy, we analyzed the extent to which the various options would reduce financial risk, reduce incentives to underserve costly beneficiaries, and improve the overall fairness of the system. We believed an outlier target of 8 percent would allow us to achieve a balance of the above stated goals. Our regression analysis showed that additional increments of outlier payments over 8 percent would reduce financial risk, but by successively smaller amounts. Since outlier payments are included in budget neutrality calculations, outlier payments would be funded by prospectively reducing the non-outlier prospective payment system payment rates by the proportion of projected outlier payments to projected total prospective payment system payments in the absence of outlier payments; the higher the outlier target, the greater the (prospective) reduction to the base payment rate.

In the proposed rule, we included a provision for outlier payments under the LTCH prospective payment system and proposed to set outlier numerical criteria prospectively before the beginning of each Federal fiscal year so that outlier payments would be projected to equal 8 percent of total payments under the LTCH prospective payment system. Based on regression analysis and payment simulations, we believed this option would optimize the extent to which we would be able to protect vulnerable hospitals, while still providing adequate payment for all other cases that are not outlier cases.

We proposed under § 412.525(a) to make an outlier payment for any discharges where the estimated cost of a case would exceed the adjusted LTCH prospective payment system payment for the LTC–DRG plus a fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under an outlier policy. This would result in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. The LTCH's loss would be limited to the fixed-loss amount and the percentage of costs above the marginal cost factor. We proposed to calculate the estimated cost of a case by multiplying the overall hospital cost-to-charge ratio by the Medicare allowable covered charge.

Our analysis of payment-to-cost ratios for outlier cases showed that a marginal cost factor of 80 percent appropriately addresses outlier cases that are significantly more expensive than non-outlier cases. This factor would ensure that there is a balance between the need to protect LTCHs financially, while encouraging them to treat expensive patients and maintaining the incentives of a prospective payment system to improve the efficient delivery of care. Based on this analysis and consistent with the marginal cost factor used under the IRF prospective payment system and under section 1886(d) of the Act for inpatient acute care hospitals, we proposed to pay outlier cases 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 LTC–DRG and the fixed-loss amount). We proposed to calculate the fixed-loss amount by simulating aggregate payments with and without an outlier policy, using FY 2000 MedPAR claims data and the best available cost report data in an iterative process to determine a fixed-loss threshold that would result in outlier payments being equal to 8 percent of total payments. For FY 2003, we proposed to implement a fixed-loss amount of $29,852 based on an outlier target of 8 percent (67 FR 13472). Therefore, for FY 2003, we proposed to pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC–DRG prospective payment system payment and the fixed-loss amount of $29,852). For this final rule, we used FY 2001 MedPAR claims data and the best available cost report data to determine a fixed-loss threshold that would result in outlier payments being equal to 8 percent of total payments. In this final rule, for FY 2003, we are implementing a fixed-loss amount of $24,450 (based on an outlier target of 8 percent) as a result of the increase in the standard Federal base rate explained in section X.K.2. of this preamble. Therefore, for FY 2003, we will pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC–DRG prospective payment system payment and the fixed-loss amount of $24,450).

Comment: One commenter believed that the outlier target is appropriately set at 8 percent of total Medicare payments to LTCHs and strongly recommended that outliers be financed using the same methods and principles currently in place for acute care hospitals. Other commenters stated that our calculation of an outlier target of 8 percent is appropriate, but asked that the calculation be reevaluated on an annual basis, and that consideration should be given to lowering the outlier target gradually down to 5 percent to be consistent with the policy established for the acute inpatient hospital prospective payment system, if the data support such a lowering of the outlier target.

Response: While our simulations, based on the best data available, showed that an outlier target of 8 percent is most appropriate at this time, considering that the LTCH prospective payment system is a new payment system, we do plan to reevaluate the outlier target payment percentage as more data on LTCHs become available and would consider proposing a change to the outlier payment percentage if warranted.

Comment: One commenter expressed concern about our reliance on the study conducted by the Rand Corporation, used for the outlier policy under the acute care hospital inpatient prospective payment system, which found that later days of a stay have considerably lower costs than the earlier days of a stay (57 FR 23640, June 4, 1992). The commenter disagreed with the findings of this study and stated that the findings are not reflective of the situation in its facility where there is a high number of ventilator weaning cases. In the commenter's facility, as a patient's respiratory status improves, the rehabilitation resources are increased to prepare the patient for discharge from the LTCH. The commenter also suggested that we further evaluate this study in relation to cases where a

patient makes an end of life decision to be removed from a ventilator, which, since this decision may not occur until very late into a patient's stay, can be extremely resource intensive and costly.

Response: While the findings of the RAND study (which was used for the outlier policy under the acute care hospital inpatient prospective payment system) may not typically reflect the resource usage and costs at the commenter's LTCH, they are, however, indicative in general of the trends in resource use at hospitals where the costs of later days of a stay are less than the costs of earlier days of a stay. We understand that LTCHs that treat a high number of ventilator weaning cases may have unique cost structures. However, we believe that, according to data available at this time, the final policy sufficiently reimburses LTCHs for high-cost cases.

Comment: One commenter noted that, although the fixed-loss amount in the proposed adjustment for high-cost outliers is consistent with the Medicare acute care hospital inpatient prospective payment system, an outlier policy that is more related to the costs and length of stay of each LTC–DRG would be more appropriate because many shorter stay LTC–DRGs will rarely reach the outlier threshold dollar amount. The commenter was also concerned that a fixed outlier payment may result in underpayments from some Medigap insurers. As an alternative to the uniform fixed loss amount proposed by CMS for all patients regardless of their assigned LTC–DRG, the commenter suggested a set of LTC–DRG-specific outlier thresholds that are set at a fixed multiple of the payment for each LTC–DRG. The commenter believed that a fixed multiple of slightly more than 2.0 of the LTC–DRG payment amount yields an outlier target of 8 percent, meaning that the cost for a case would generally need to exceed twice the payment amount to qualify for outlier payments. The commenter believed that this approach distributes outlier payments evenly across LTC–DRG case types and across LTCHs.

Another commenter questioned our proposal to set the fixed-loss amount across all LTC–DRGs at a fixed amount, and stated that, given the small number of LTCHs and the wide variety of patients treated relative to acute care hospitals, such a fixed policy may inappropriately assume that the underlying cause of all high-cost cases is the same across LTC–DRGs. The commenter explained that LTCHs that treat a disproportionate number of patients who are unlikely to be discharged in a timely manner, including patients with spinal cord injuries or who require a ventilator, might experience significant losses serving those patients. The commenter requested that we consider varying the fixed-loss threshold and the outlier payment percentage by LTC–DRG to ensure that LTCHs with longer than average stays receive adequate payment.

Other commenters stated that the proposed outlier target of 8 percent is too low and will place an unfair financial burden on facilities that treat patients with ''clinically appropriate'' long stays. One commenter explained that, since its facility specializes in caring for ventilator-dependent patients who have ''complex, highly acute long lengths of stay'', the proposed outlier policy would create a ''significant and unrealistic economic burden'' on the facility. The commenter suggested that, if the proposed outlier target is not increased, we should reevaluate which DRGs have the most outliers and why. The commenter assumed that ''true outliers'' are primarily grouped in a very small number of LTC–DRGs.

As an alternative to the proposed outlier policy, the commenter suggested that we consider creating a specific category of LTCHs that would meet ''minimum volume threshold'' levels for certain types of patients, such as ventilator weaning. Under the commenter's proposal, if providers meet a minimum number of cases per year and if the threshold has been met, these highly specialized facilities may qualify to receive additional reimbursement without having to incur fixed losses for cases with long lengths of stay. The commenter recommended a threshold of 130 cases per year, given that there are approximately 270 LTCHs and 70,000 yearly discharges nationally. Since the national average number of discharges per facility is 260, a threshold of 130 cases would indicate that a significant proportion of a facility's patients must be in a specific DRG category. The commenter also suggested that we create an additional LTC–DRG for excessively long lengths of stay, which would be constructed in a way so as not to provide any financial gain to facilities that continue to keep patients in a LTCH beyond the arithmetic mean length of stay in a given LTC–DRG. This suggested additional LTC–DRG would provide reimbursement that is appropriate to cover the costs of treating patients in facilities with specialized programs.

Response: In a prospective payment system based on DRGs, the amount of funds designated for high-cost outliers and the methodology used to make these payments must balance the conflicting considerations of the need to protect hospitals with costly cases, while maintaining incentives to improve overall efficiency. In this regard, we believe the payment methodology should focus on improving efficiency in the treatment of the cases, where the greatest amount of control can be exercised, in order to compensate somewhat for the ''losses'' incurred in treating the more costly cases that are less predictable and more difficult to control.

In selecting an outlier policy, the first consideration is the amount that a hospital will ''lose'' before outlier payments begin. The ''loss'' should be significant enough to avoid an incentive to reach the outlier threshold, yet not large enough to create excessive financial hardship. Since the proposed FY 2003 LTCH standard Federal rate was $27,649.02, as a measure of scale, we believed that the fixed-loss amount should relate to this amount. We did examine the impact of setting the outlier target percentage at 5 percent, 8 percent, and 10 percent. We found that an outlier target of 8 percent is the most reasonable since our regression analysis showed that additional increments of outlier payments over 8 percent would reduce financial risk, but by successively smaller amounts. In addition, since the LTCH prospective payment system is a budget neutral payment system, any increase in outlier payment must be offset by a decrease in payment for all discharges that are not outliers.

Given the range in the costs of each case treated across all LTCHs, we believe that a policy that uses a uniform fixed-loss amount for all LTC–DRGs is most equitable. Use of a fixed-loss amount avoids creating an outlier payment incentive to differentially accept or treat patients in different LTC–DRGs, or both. That is, if cases in one LTC–DRG become eligible for outlier payments after a $10,000 loss is incurred, whereas cases in another LTC–DRG must incur a $20,000 loss before qualifying for outlier payments, cases in the first LTC–DRG might be favored and greater efforts might be made to limit acceptance and treatment of cases in the second LTC–DRG. We believe that it is particularly important to avoid such an incentive, given the tendency for certain LTCHs to specialize in treating specific types of patients, some which may be extremely costly. Therefore, we are not adopting the commenter's proposal to vary the fixed-loss amount by each LTC–DRG.

We also examined the impact of a marginal cost factor of 55 percent instead of the 80-percent factor that was

proposed. Under either marginal cost factor, while the amount designated for payment of high-cost outliers would remain set at 8 percent, the higher the marginal cost factor, the higher the fixed-loss amount. Our analysis showed that a marginal cost factor of 80 percent is most suitable because, under this method using a higher threshold, the cases identified as outliers are very expensive, whereas the additional cases that would qualify for an outlier payment due to the lower threshold under a marginal cost factor of 55 percent are not unusually expensive. Our intent is to reimburse a LTCH for only those outlier cases that are unusually costly. We believe that, by establishing the fixed-loss amount at $24,450 based on more recent available data (instead of the proposed $29,852) with the concomitant marginal cost factor of 80 percent, we are ensuring that only the unusually costly cases would qualify for additional reimbursement. Alternatively, if a marginal cost factor of 55 percent would be used to maintain the 8 percent target, the fixed-loss amount would necessarily be lowered, allowing for additional, less costly cases to qualify for a portion of the 8-percent outlier target. Therefore, we believe that the marginal cost factor of 80 percent most appropriately addresses outlier cases that are significantly more expensive than nonoutlier cases while simultaneously maintaining the integrity of the LTCH prospective payment system.

In addition, we did not vary the outlier target percentage by each LTC-DRG in order to allow for Medigap payments in lower-payment LTC–DRGs, nor did we create ''minimum volume thresholds'' for specific cases, because to do so would unnecessarily provide outlier payments for all cases, including those that are relatively inexpensive. Varying the outlier target by LTC–DRG would inappropriately distribute payment for high-cost outliers over all cases, thereby reducing the resources available to finance those with truly high costs. Under the aggregate outlier target that we proposed, every LTC–DRG is, in effect, ''funding'' the outlier target, leaving more resources available to cover the high-cost outliers. We believe that this is the most reasonable method of implementing a stop-loss on the unusually high-cost cases. Furthermore, the method of using an outlier target that applies across all LTC–DRGs is consistent with the method used under the acute care hospital inpatient prospective payment system and IRF prospective payment system.

Finally, we are not adopting a policy that accounts for long-stay outliers because, according to our analysis, while high-cost outlier cases tend to fall in the tracheostomy, ventilator management, and respiratory failure DRGs, long-stay outliers are not always concentrated in these same categories identified by the high-cost outlier methodology. Because we believe it is important to focus on mitigating the losses incurred when treating extremely costly cases, we do not believe it is necessary to separately account for long-stay outliers at this time.

In summary, while we are not adopting the commenters' recommendations concerning high-cost outliers at this time, we do intend to reevaluate the possibility of a system based on severity-adjusted LTC–DRGs as more accurate data become available and may propose changes in our policy if they are warranted.

Comment: One commenter believed that while additional payments for outliers are appropriate to help cover the costs of unusually high-cost patients, the proposed outlier target of 8 percent is too high and may pose a risk of undermining the goals of the LTCH prospective payment system. The commenter asserted that an outlier target of 8 percent may create an incentive for LTCHs to ''hang on to'' patients that should more appropriately be discharged for care in a lower cost setting. The commenter noted that the prospective payment system for IRFs established an outlier target of 3 percent and the outlier target under the acute care hospital inpatient prospective payment system is established between 5 and 6 percent of aggregate payments. The commenter recommended that a more appropriate outlier target for LTCHs would be one that is reduced to 3 percent.

Response: As we explained in the preamble of the proposed rule (67 FR 13468–13469), a smaller outlier target within the range of 5 to 6 percent was evaluated, but statistically, it did not perform as well as the higher outlier target of 8 percent, since the payment-to-cost ratios were significantly higher with the 8-percent outlier target. In addition, an outlier target of only 5 percent would increase the fixed-loss amount to approximately $45,000, representing a large ''loss'' to the LTCH before an outlier payment would be made. Such a high fixed-loss amount would seem to engender the financial hardship that a high-cost outlier policy is intended to mitigate. An outlier target of 8 percent takes a more conservative approach in helping to minimize the financial risk across all LTCHs. Further, the IRF prospective payment system is not analogous to the LTCH prospective payment system in this respect since the cases at IRFs are significantly more homogeneous than those treated at LTCHs. However, as with the other payment policies under the LTCH prospective payment system, we intend to review the high-cost outlier policy when more data on LTCH payments become available, and may propose changes in this policy in the future if they are warranted.

Comment: One commenter stated that the outlier payment calculation is skewed because of the number of ''new'' facilities involved. The commenter took issue with our estimate of outliers based on cost-to-charge ratios derived from the initial cost reporting periods of the ''new'' LTCHs, where costs are typically inflated due to the establishment of the TEFRA base rates and was concerned that the LTCH prospective payment system, including outlier payments, was based on those ''inflated'' costs. In order to mitigate the problems that arise from reliance on data from ''new'' LTCHs, the commenter recommended that we reexamine the relevant data for all LTCHs and devise a methodology that takes into account the large number of ''new'' LTCHs included in the sample and the abnormally high costs associated with ''new'' LTCHs.

Response: Under § 413.40, a hospital that is excluded from the inpatient prospective payment system is paid on a reasonable cost basis subject to a target amount per discharge. A ''new'' LTCH's target amount is based on the costs incurred in the first full 12 month cost reporting period. In order to establish higher target amounts under the TEFRA payment methodology, ''new'' LTCHs have an incentive to maximize their costs in their TEFRA base periods. As a result, as the commenter indicated, cost data from the initial years of a ''new'' LTCH may have been inflated since those costs are the basis for the hospital's TEFRA target amount in subsequent years. While we are aware that there are some limitations to the data, the data that we used were the best available at that time. In future years, the outlier threshold will be reevaluated as more data on LTCHs become available and behaviors change. However, the current data show that an outlier target of 8 percent is statistically and empirically appropriate as a means of providing LTCHs with additional protection against unusually costly cases.

Comment: Some commenters explained that when they applied the proposed outlier calculation rules to the actual MedPAR 2000 file, the total

amount of payments for high-cost outlier cases appeared to be more than 8 percent of the total payment amount. The commenters requested that we explain the methodology used to calculate the 8 percent outlier target and why the commenters' results may differ from those of CMS'. The commenters also asked if the 80-percent reduction in high-cost outliers was considered in the outlier payment amounts shown in the rate-setting file (posted on the CMS website).

Response: When we simulated the LTC–DRG relative weights and the high-cost outlier payments under the LTCH prospective payment system for the proposed rule, we used the best data available from a total of 251 LTCHs for which MedPAR (claims) case-mix data and cost-to-charge ratios were available. For the proposed rule, when all 251 LTCHs were used, an outlier target of 8 percent (8.00007) resulted. However, for the proposed rule, we only had reliable data to estimate total TEFRA payments for 211 LTCHs. Therefore, in calculating a base rate that would result in total LTCH prospective payment system payments being budget neutral to total payments under the TEFRA methodology, in the proposed rule, we used only 211 LTCHs (as shown in the rate-setting file on the CMS website).

As we discuss in greater detail in section X.K.2.a. of this preamble, for this final rule, we used the data from all LTCHs (except for LTCHs that are also all-inclusive rate providers or reimbursed in accordance with demonstration projects (see section X.K.2.a. of this preamble)) for which we had claims data and cost-to-charge ratios to determine the high cost outlier threshold. Therefore, from the data that we had available for this final rule, we used data from 246 LTCHs in determining the final FY 2003 fixed-loss amount of $24,450. However, as explained above and in further detail in section X.K.2.a. of this preamble, for this final rule, we could only use the data from 194 LTCHs for which we had data available to estimate total TEFRA payments in the determination of the final budget neutral base rate.

There may be numerous reasons why the commenters' payment simulation differed from our simulations, and without knowing exactly how the commenters simulated the payments or what data were included, we cannot pinpoint a cause of the variation. If the commenters used the rate-setting file posted on our website as the basis for their simulations, their results should have matched the results from CMS. We note, however, that a simulation of outlier payments using only 211 LTCHs would result in an outlier target of approximately 7.8 percent. In addition, the 80-percent marginal cost factor was also included in the outlier payment amounts shown in the rate-setting file.

Comment: One commenter stated that the proposed fixed-loss amount of $29,852 is unfair to LTCHs since short-term acute care hospitals only have to reach a loss of around $19,000 in order to qualify for an additional outlier payment.

Response: The commenter has mistakenly attributed a fixed-loss amount of approximately $19,000 to acute care (short-term) hospitals. For FY 2001, under the acute care hospital inpatient prospective payment system, the fixed-loss amount was $17,550; for FY 2002, the fixed-loss amount is $21,025. However, the fixed-loss amount for FY 2003 for acute care hospitals is $33,560 (67 FR 50124, August 1, 2002), which is actually higher than the proposed fixed-loss amount of $29,852 ($24,450 in this final rule) for FY 2003 for LTCHs. Thus, contrary to the commenter's assertion that the fixed-loss amount for LTCHs is unfair relative to the outlier fixed-loss amount for acute care hospitals, LTCHs would incur less cost than acute care hospitals before qualifying for additional outlier payments.

Comment: One commenter requested that we revise proposed § 412.525 to specifically state that payments made for high-cost outliers are not subject to retroactive adjustments for changes made to a provider's hospital-specific cost-to-charge ratio.

Response: Under the proposed § 412.525, the additional outlier payment equals 80 percent of the difference between the estimated cost of the patient case and the sum of the adjusted Federal prospective payment for the LTC–DRG and the fixed-loss amount. The estimated cost of a case is calculated by multiplying the overall hospital cost-to-charge ratio by the Medicare allowable covered charge. As implied by the commenter, although the outlier payment is based, in part, on the estimated cost of a case, no retroactive adjustments are made to the outlier payments upon cost report settlement to account for the differences between the estimated cost-to-charge ratios and the actual cost-to-charge ratios. This is standard operating policy for fiscal intermediaries for all prospective payment systems because adjustments for individual high-cost outliers would be costly to Medicare as well as administratively burdensome. We are adding this clarification as § 412.525(a) in this final rule. In addition, we are modifying § 412.525(a) to clarify that the estimated cost of a patient's care is determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge.

Provisions of the final rule. After analysis of public comments on our proposed policy on additional payments for high-cost outlier cases (§ 412.525(a)), we have found that the proposed policy continues to be supported by appropriate data and are, therefore, adopting it as final. Therefore, we will make additional outlier payments to LTCHs for any discharges where the estimated cost for a patient case exceeds the sum of adjusted LTCH prospective payment for the LTC–DRG and a fixed-loss amount. We have set the outlier target at 8 percent of total Medicare payments to LTCHs using a total of 246 LTCHs for which we have MedPAR data. The final fixed-loss amount for FY 2003 is $24,450. For each fiscal year we will determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the prospective payment system for a case with unusually high costs before the hospital will receive any additional payments. The fixed loss amount will result in estimated total outlier payments being equal to 8 percent of projected total LTCH prospective payment system payments. We will pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC–DRG prospective payment and the fixed-loss amount). In response to a comment, we are revising § 412.525(a) to clarify that no retroactive adjustment will be made to the outlier payment upon cost report settlement to account for differences between the estimated cost-to-charge ratios and the actual cost-to-charge ratios for outlier cases. We are also modifying § 412.525(a) to clarify that the estimated cost of a patient case is determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge.

In addition, while we were developing the final short-stay outlier policy as described in section X.C. of this preamble, we became aware that, under some rare circumstances, a LTCH discharge could qualify as a short-stay outlier case and also as a high-cost outlier case. In such a scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the outlier threshold (that is, the short-stay outlier payment plus the fixed-loss amount), the discharge would be eligible for payment as a high-cost outlier. The

payment would be based on 80 percent of the difference between the estimated cost of the case plus the outlier threshold (the sum of the fixed-loss amount of $24,450 for FY 2003 and the amount paid under the short stay outlier policy).

K. Calculation of the Standard Federal Payment Rate

1. Overview of the Development of the Standard Payment Rate

Section 123(a)(1) of Public Law 106–113 requires that the prospective payment system for LTCHs maintain budget neutrality. Therefore, we will calculate the standard Federal rate by setting total estimated prospective payment system payments equal to estimated payments that would have been made under the TEFRA methodology if the prospective payment system for LTCH were not implemented as described in this final rule. In accordance with section 307(a)(2) of the BIPA, the increases to the hospital-specific target amounts and cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of the BIPA and the enhanced bonus payments for LTCHs for FY 2001 and FY 2002 provided for by section 122 of the BBRA were not taken into account in the development of the prospective payment system for LTCHs.

The methodology for determining the standard Federal payment rate under the LTCH prospective payment system is described in further detail below.

2. Development of the Standard Federal Payment Rate

a. Data Sources

In this final rule, the data sources that we used to calculate the final unadjusted standard Federal payment rate include cost report data from FYs 1996 through 1999 and FY 2001 Medicare claims data from the March 2002 update of the MedPAR files since these data were the most recently available complete data for LTCHs. We used data from 194 LTCHs in this final rule to calculate the final standard Federal payment rate. We updated the cost report data for each LTCH to the midpoint of FY 2003 using an inflation factor based on the historical relationship of each hospital's costs and their target amounts (see section X.K.2.b. of this preamble). The FY 1996 cost report data were used to determine each LTCH's update for FY 1999, and the FY 1997 cost report data were used to determine the update for FY 2000. The FY 1998 cost report data were used to determine the update for FY 2001, and the FY 1999 cost report data were used to determine the update for FY 2002. For this final rule, we were unable to estimate payments under the current payment system for some LTCHs because cost report data were unavailable.

For this final rule, we obtained the most recent available payment amounts for hospitals and have used these data to construct the standard Federal payment rates in this final rule, as explained below. As we indicated in the proposed rule, we examined the extent to which certain LTCHs (new LTCHs, for example) were not included in the data used to determine the proposed standard Federal payment rate, but were unable to determine an appropriate adjustment to better reflect total estimated payments for those LTCHs under the TEFRA payments system. As described above, for this final rule, we used the most recently available complete data for LTCHs, that is, cost report data from the March 2002 update of HCRIS and claims data from the March 2002 update of the MedPAR files. As we explain below, based on concerns with the data used to develop the proposed LTCH prospective payment system, we have excluded the data from 17 all-inclusive rate providers in the development of the final LTCH payment rates.

Comment: Several commenters expressed concern about the quality of the data behind policy choices for the prospective payment system and urged CMS to revisit these policies once better data has been gathered.

Response: In designing the LTCH prospective payment system, we were required by BIPA to use ''the most recently available hospital discharge data'' for our policy determinations. The particular data sets we used are detailed in this section and additional factors that influenced our choices are noted in our discussion in section X.K.2. of this final rule. As we state previously, we used the best available data and we have confidence that our policies effectively satisfy the statutory mandates under Public Law 106–113 and Public Law 106–554. We will be monitoring and evaluating the new system and are prepared to revisit and revise these policies in the future, if warranted.

Comment: One commenter stated that we used cost report and MedPAR data from only 222 LTCHs to set the proposed rates, while as of November 2001, there were 270 LTCHs in existence. The commenter also stated that it was unclear how many LTCHs we used in our analysis since 211 LTCHs were included in the rate-setting file posted on the our website, and there were 222 LTCHs included in the adjustment (regression) file. The commenter contended that if we did in fact use the data from all 222 LTCHs, this means that we have improperly denied the public access to the data we used in setting the proposed rates.

Response: The data we used for the proposed rates were the best data available to us at that time as required by section 307 of Public Law 106–554. All of the data we used to calculate the proposed rates and to analyze proposed adjustments were posted on our website and were accessible to the public. The number of LTCHs that we included in each file was dependent upon the amount of data that we had available for each hospital and the data needed for the specific calculation. Many LTCHs had incomplete records in either the MedPAR or HCRIS files, or both. When we calculated the relative weights and estimated high cost outlier payments under the LTCH prospective payment system for the proposed rule, we used the best available data at that time from a total of 251 LTCHs, since we had MedPAR (claims) data and cost-to-charge ratios available for these 251 LTCHs. However, we only had complete data for 211 LTCHs to estimate total payments under the TEFRA payment system. Therefore, in calculating a proposed budget neutral Federal rate, which would result in total LTCH prospective payment system payments estimated to equal total payments that would have been made under the TEFRA payment system, we were only able to use data from 211 LTCHs. Thus, the rate-setting file posted on our website includes only 211 LTCHs. Because total TEFRA payments are not a factor used in the regression analysis used to examine potential payment system adjustments in the proposed rule, we were able to include data from 11 more hospitals (for a total of 222) in the adjustment file posted on our website.

Based on the concern expressed by a number of commenters regarding the data used to develop the proposed LTCH prospective payment system, we reviewed the LTCH data that we used in our proposed rule and have reevaluated the inclusion of data from certain types of LTCHs. Specifically, in this final rule, we have not included data from LTCHs that are also all-inclusive rate providers (AIRPs) and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 395b–1).

Patient charges and costs reported by AIRPs are computed differently from those of other providers. Hospitals with

an ''all-inclusive rate'' charge structure combine routine, ancillary, and capital costs into one global patient per diem charge and do not report Medicare patient charges on their cost reports. The absence of a charge structure precludes the normal allocation of costs to the Medicare program for ancillary services, because Medicare patients' charges cannot be accumulated. Thus, the charge data from the MedPAR files and the cost data from the cost reports do not reflect Medicare costs and related resource use in the same manner as it does for the majority of other Medicare providers.

We do not believe that either the charges or the costs reported by LTCHS that are also AIRPs are at all comparable to the data reported for other LTCHs and, therefore, have the potential to inappropriately skew relative weight determinations, regression analyses, and rate calculations for the entire LTCH prospective payment system. As a result, in order to prevent potential distortion to the LTCH prospective payment system, we have decided to exclude the data from the 17 AIRPs in the development of the LTCH prospective payment system in this final rule. Thus, only data from LTCHs with more detailed charge and cost data were used in assessing the validity of potential payment adjustments and in the determination of the final LTC-DRG relative weights and Federal rate that appear in this final rule. Furthermore, excluding the AIRPs' data is consistent with the methodology used in establishing the IRF prospective payment system (see 66 FR 41351 (August 7, 2001)).

We have also excluded the data from the 3 LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b—1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1), since these LTCHs are not subject to the LTCH prospective payment system.

After considering the commenters' concern that, currently, there are significantly more LTCHs in existence than were used in the development of the proposed LTCH prospective payment system, for this final rule, we are clarifying that for both the proposed and final rules, we used all LTCHs for which we had MedPAR (claims) data and cost-to-charge ratios available (except for this final rule we excluded LTCHs that are AIRPs or reimbursed in accordance with demonstration projects), for a total of 246 LTCHs, to calculate the relative weights. For this final rule, we used the most recently available claims data from the March 2002 update of the FY 2001 MedPAR files and updated LTCH cost and TEFRA payment information from the March 2002 update of HCRIS. Accordingly, we included the data for 198 LTCHs in the regression analyses and the data for 194 LTCHs in calculating the final FY 2003 Federal rate. These are fewer than the number of LTCHs that were used in the proposed rule since we have excluded for this final rule LTCHs that are AIRPs or reimbursed in accordance with demonstration projects.

Comment: One commenter indicated that five of its LTCHs were not included in the rate-setting file posted on our website. The commenter wanted to know why these facilities were excluded and what the impact of excluding them was on the proposed weights and total payment calculations.

Response: The LTCHs indicated by the commenter were omitted from the rate-setting file on the website because they did not have sufficient cost report information in HCRIS to estimate payments under the TEFRA payment system, and consequently, we could not include them in the calculation of a budget neutral rate. Since we had claims data for these 5 providers and since the relative weights were determined using claims data from the MedPAR files, these LTCHs were included in the determination of the relative weights. However, since we needed specific cost report data to estimate TEFRA payments and since we did not have specific cost report information available for these providers, we are not able to determine the effect this information would have had on the proposed or final payment calculations.

Comment: One commenter noticed that 39 facilities observed in the MedPAR FY 2000 files were excluded from the analysis used to create the rate-setting file posted on our website. The commenter assumed these facilities are excluded from the summation of total payments in the rate-setting file, and asked what the impact would be on budget neutrality and total payments if these additional hospitals would be included.

Response: As we explained above, we were only able to include those LTCHs in our analysis from which we had sufficient cost report data to estimate payments under the TEFRA payment system. Since publication of the proposed rule, we have received some additional cost reports, which we have included in our analysis for this final rule. Since we cannot determine what the costs and payments were under the TEFRA payment system without cost report data for the LTCHs for which we do not have sufficient cost data, we also cannot determine what the impact would be on the standard Federal rate if these facilities would have been included in our analysis.

Comment: Some commenters wanted to know why their hospitals' internal cost report data did not match the data in our rate-setting file.

Response: The commenters did not provide specific information about their hospitals' internal cost report data that did not match the data posted on our website. Therefore, we cannot determine a particular reason for the variation between our cost report data in HCRIS and the commenters' internal cost report data. We accessed our cost report information from the June 2001 update of HCRIS for the most recent available cost reporting period (either FYs 1998 or 1999). The commenters might have been using settled cost report data, while the data in the cost reports that were available to us at the time of our calculations for the proposed rule were data from as-filed cost reports. We also note that although the cost report data on the rate-setting file were from FYs 1998 or 1999, the data were updated to FY 2003 using the excluded hospital market basket.

Comment: One commenter requested that we provide detailed computations, by patient, in the rate-setting file. Another commenter suggested that the rate-setting file should show the impact of the proposed interrupted stay policy.

Response: In order to show patient-specific computations and the impact of the proposed interrupted stay policy, we would have needed patient-specific cost data. Since the Medicare cost reports do not provide patient-specific statistics, we are not able to demonstrate the impact of the interrupted stay policy.

Comment: One commenter wanted to know which rate-setting file variables reflect updated cost report information beyond FY 1998 and FY 1999 and how this updated cost report information was applied in the rate-setting formulas.

Response: As we stated in the March 22, 2002 proposed rule (67 FR 13470), all cost and payment information is inflated to FY 2003. Thus, the following variables are already inflated to FY 2003: ''Operating Cost Per Case'', ''Capital Cost Per Case'', ''TEFRA Payment Per Case'', ''Total TEFRA Payment'', ''PPS Payments (Excluding Outlier Payments)'', ''Outlier Payments'', and ''Total PPS Payments.'' These cost and payment variables were used to estimate TEFRA payments used to calculate a budget neutral rate.

Comment: A commenter asked if the ''outlier payments'' variable in the rate-setting file refers to high-cost outlier

payments only. The commenter also asked if the cost-to-charge ratio applied to charges from the MedPAR data and if the outlier costs were determined per case.

Response: The ''outlier payments'' variable in the rate-setting file refers to high-cost outlier payments only (as described in section X.J.6. of this preamble). We applied the cost-to-charge ratio to the charges for each case from the MedPAR data to determine the outlier costs for each case.

As we discussed in the March 22, 2002 proposed rule (67 FR 13469), in determining the prospective payment rates for LTCHs, we had significant concerns about the integrity of some of the cost report data in HCRIS. Specifically, we were concerned about data from cost reports submitted by a hospital chain that is the owner of approximately 20 percent of LTCHs nationwide that arose from a ''qui tam'' action filed by the U.S. Department of Justice (DOJ) in July 1999. This action alleged, among other claims, that the hospitals inflated both cost and charge data on Medicare hospital cost reports filed from FYs 1994 through 1999. On March 16, 2001, the hospital chain agreed to pay approximately $339 million to settle claims arising from 11 separate actions. Based upon audits and projections performed by Medicare's fiscal intermediary under the direction of our Office of Financial Management, the Medicare LTCH action was allocated $178 million of this settlement.

Under the terms of the agreement, Medicare cost reports from the years in question were not reopened and audited. However, the fiscal intermediary was able to estimate the effect on the Medicare cost reports for 1995, 1996, and 1997. Then a random sample of Medicare cost reports from 1998 and 1999 were reviewed to verify the projected impact for those years and a settlement figure was determined for FY 1995 through FY 1999. Therefore, in order to avoid the negative impact those providers' data may otherwise have on the integrity of the data, as we did in the proposed rule, we are basing our final standard Federal rate on a factor determined by our Office of the Actuary to adjust the costs reported in those affected FY 1998 and FY 1999 cost reports. This factor was derived by determining the ratio of the portion of the settlement amount described above attributable to each affected LTCH to the Medicare payments received by each affected LTCH during the period covered by the settlement.

Comment: Some commenters asked how the qui tam adjustment was calculated.

Response: If the affected LTCH had a cost report for a period after the settlement, no adjustment was made. An adjustment was made only if that LTCH's latest cost report was for a period covered by the settlement. The adjustment for that LTCH was equal to the amount of the adjustment attributable to that LTCH, divided by the amount of payments that LTCH received for that period according to the cost report. This ratio was then used to reduce payments in FY 2003 to be included in the calculation of the Federal rate and budget neutrality. When the ratio was calculated for the proposed rule, it was possible that a particular hospital may have had settlement data for a cost reporting period after FY 1999. However, cost report data for such a LTCH were not available to us because we did not have HCRIS files for any fiscal year after FY 1999 at that time. Thus, such a LTCH's payments under the TEFRA system could not be calculated with data more recent than FY 1999. In maintaining budget neutrality, we used the most recent year's data available (either FY 1998 or FY 1999). Thus, since the cost report data was overstated as specified in the qui tam settlement, we modified the cost report data to correct for the effects of the settlement.

Comment: A commenter stated that the settlement amount allocated to Medicare LTCH action peaked in FY 1998 at $47 million and decreased to $27 million in FY 1999 and $0 in FY 2000 and going forward. The commenter stated that it appears from the ratesetting file that a downward $47 million adjustment was applied to the updated FY 2003 payment amount for the affected hospitals. The commenter believed a better methodology would be to apply a $27 million reduction to the FY 1999 actual costs for the affected hospitals and trend the actual adjusted amounts forward rather than making an adjustment to the updated amount in FY 2003.

Response: For the proposed rule, if we did not have cost report data for a period after the settlement, the qui tam adjustment was applied since the most recent cost report that we had available to use for estimating FY 2003 payments under the TEFRA payment system was for a period covered by the settlement. The amount paid was adjusted by a factor equal to the amount of the settlement attributable to that LTCH during that specific cost reporting period divided by the total payments received by that LTCH during that cost reporting period. Since the latest available cost report data (either FY 1998 or FY 1999) was used as a base to project future costs and payments under the TEFRA payment system, we believe that only the payment information for those affected LTCHs for which we had to use questionable cost report data should be adjusted. As we stated in proposed rule (67 FR 13470), where the latest available cost report for a LTCH was for FY 1999, we adjusted the costs reported in the affected LTCH's FY 1999 cost report. Thus, as the commenter stated, the adjustment was limited to the $27 million reduction and that adjusted FY 1999 data was trended forward to FY 2003 to estimate payments under the TEFRA payment system for FY 2003 used in the budget-neutrality calculations.

b. Update the latest cost report data to the midpoint of FY 2003.

For both the proposed rule and this final rule, and consistent with the methodology used under the IRF prospective payment system (§ 412.624(c)), we are updating (§ 412.523(c)(2)), each LTCH's cost per discharge to the midpoint of FY 2003, using the weighted average of the applicable percentage increases to the TEFRA target amounts for FYs 1999 through 2002 (in accordance with § 413.40(c)(3)(vii)) and the full market basket percentage increase for FY 2003. For FYs 1999 through 2002, in this final rule, we determined the appropriate update factor for each hospital by using the methodology described below:

- For hospitals with costs that equal or exceed their target amounts by 10 percent or more for the most recent cost reporting period for which information is available, the update factor is the market basket percentage increase.
- For hospitals that exceed their target amounts by less than 10 percent, the update factor is equal to the market basket minus 0.25 percentage points for each percentage point by which operating costs are less than 10 percent over the target (but in no case less than 0).
- For hospitals that are at or below their target amounts, but exceed two-thirds of the target amounts, the update factor is the market basket minus 2.5 percentage points (but in no case less than 0).
- For hospitals that do not exceed two-thirds of their target amounts, the update factor is 0 percent.

For FY 2003, we used the most recent estimate of the percentage increase projected by the excluded hospital market basket index.

Comment: Some commenters questioned CMS's methodology for applying the market basket percentage to update the cost report data from FY 1996 through FY 1999 to the midpoint

of FY 2003. Specifically, the commenters were concerned that the bonus and penalty payments under the TEFRA payment system methodology (§ 413.40(d)(2) and (3)) were not accounted for when applying the market basket update. The commenters requested that CMS explain how it accounts for cost growth for hospitals whose costs are below the TEFRA caps.

Response: We proposed to update each LTCH's cost per discharge to the midpoint of FY 2003, using the weighted average of the applicable percentage increases to the TEFRA target amounts for FYs 1999 through 2002 (in accordance with § 413.40(c)(3)(vii)) and the full market basket percentage increase for FY 2003. We also updated each LTCH's target amount using the rate-of-increase percentage as described in § 413.40(b)(3). However, within each year from FY 1999 through FY 2003, we compared each LTCH's costs to its respective target amount in order to determine the payment to each LTCH considering the rules for bonus and penalty payments under § 413.40(d)(2) and (3). Therefore, although we did not state this explicitly in the proposed rule, we did account for the bonus and penalty payments under the TEFRA payment system methodology at § 413.40(d)(2) and (3) and have done so in our analysis for this final rule, as well. We note that this was the same methodology that was applied under the IRF prospective payment system.

Comment: Some commenters stated that there should be annual market basket updates after the first year, and calculated in the first year.

Response: In the March 22, 2002 proposed rule, we proposed to update each LTCH's cost per discharge to the midpoint of FY 2003, using the weighted average of the applicable percentage increases to the TEFRA target amounts for FYs 1999 through 2002 (in accordance with § 413.40(c)(3)(vii)) and the full market basket percentage increase for FY 2003. We updated each LTCH's target amount using the rate-of-increase percentage as described in § 413.40(b)(3). In accordance with § 412.523(c)(3)(ii), and as we proposed, for fiscal years after FY 2003 the LTCH prospective payment system Federal rate will be the previous fiscal year's Federal rate updated by the most recent estimate of the LTCH prospective payment system market basket (that is, the excluded hospital with capital market basket).

c. Estimate total payments under the current (TEFRA) payment system.

We estimated payments for inpatient operating services under the TEFRA system using the following methodology:

Step 1: Determine each LTCH's hospital-specific target amount.

The hospital-specific target amount for a LTCH is calculated based on the hospital's allowable inpatient operating cost per discharge for the hospital's base period, excluding capital-related, nonphysician anesthetist, and medical education costs. This target amount is then updated using a rate-of-increase percentage as described in § 413.40(b)(3). For FYs 1998 through 2002, there are two national caps on the payment amounts for LTCHs. Under § 413.40(c)(4)(iii), a LTCH's hospital-specific target is the lower of its net allowable base-year costs per discharge increased by the applicable update factors or the cap for the applicable cost reporting period. In determining each LTCH's hospital-specific target amount, we use the FY 2002 cap amounts published in the hospital inpatient prospective payment system August 1, 2001 final rule (66 FR 39915–39916), adjusted in accordance with section 307(a)(2) of Public Law 106–554 by removing the 2-percent increase in the cap for existing LTCHs required by section 307(a)(1) of Public Law 106–554. For existing hospitals (that is, LTCHs paid as an excluded hospital before October 1, 1997), the applicable cap amount for FY 2002 is $30,783 for the labor-related share adjusted by the applicable geographic wage index and added to $12,238 for the nonlabor-related share. For current ''new'' hospitals (that is, LTCHs first paid as an excluded hospital on or after October 1, 1997), the cap amount applicable for FY 2002 is $16,701 for the labor-related share adjusted by the applicable geographic wage index and added to $6,640 for the nonlabor-related share. These capped amounts are inflated to the midpoint of FY 2003 by applying the excluded hospital operating market basket.

As explained above, we note that, in accordance with section 307(a)(2) of the BIPA, in estimating total payments to LTCHs under the current payment system, the increase to the hospital target amounts and caps on the target amounts for LTCHs effective from October 1, 2001 through September 30, 2002, provided for under section 307(a)(1) of the BIPA were not to be taken into account. Furthermore, as we discussed previously in this section, as a result of a qui tam action involving some LTCHs, we adjusted such affected LTCHs' cost report data by a factor equal to the amount of the settlement attributable to that LTCH during that specific cost reporting period divided by the total payments received by that LTCH during that cost reporting period.

Step 2: Determine each LTCH's payment amount for inpatient operating services.

Under the TEFRA system, a LTCH's payment amount for inpatient operating services is the lower of—

- The hospital-specific target amount (subject to the application of the cap as determined in Step 1) times the number of Medicare discharges (the ceiling); or
- The hospital average inpatient operating cost per case times the number of Medicare discharges.

In addition, under the TEFRA system, payments may include a bonus or relief payment, as follows:

- For LTCHs whose net inpatient operating costs are lower than or equal to the ceiling, payment is the lower of either the net inpatient operating costs plus 15 percent of the difference between the inpatient operating costs and the ceiling or the net inpatient operating costs plus 2 percent of the ceiling.
- For LTCHs whose net inpatient operating costs are greater than the ceiling, but less than 110 percent of the ceiling, payment is the ceiling.
- For LTCHs whose net inpatient operating costs are greater than 110 percent of the ceiling, payment is the ceiling plus the lower of 50 percent of the difference between the 110 percent of the ceiling and the net inpatient operating costs or 10 percent of the ceiling.

Comment: A commenter asked how the average operating costs per case were calculated from the cost report variables.

Response: Using data from the cost report, we determined the average operating cost per case by dividing total Medicare inpatient operating costs for the cost reporting period from worksheet D–1, adjusted by the qui tam factor, if applicable, by the total number of Medicare discharges for the same cost reporting period from worksheet S–3.

Comment: A commenter noted that operating costs are described as being ''estimated operating cost per case based on cost report data trended forward to FY 2003 using historical cost report data,'' and asked for an explanation of the term ''trended forward''. The commenter also asked what calculation was used to ''trend forward,'' and whether the operating costs calculated using total operating cost from the FY 1998 and FY 1999 cost reports were multiplied by the inflation factor of 3.6 percent.

Response: The term ''trended forward'' means that the FY 1998 or FY

1999 costs were multiplied by the market basket update of 3.6 percent to inflate those costs to FY 2003.

Further, under the TEFRA system, excluded hospitals and units, including LTCHs, may be eligible for continuous improvement bonus payments as described under § 413.40(d)(4). As explained above, in accordance with section 307(a)(2) of Public Law 106–554, the enhancement of continuous improvement bonus payments for LTCHs, effective for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2002, and provided for under section 122 of Public Law 106–113, were not to be taken into account in estimating total payments to LTCHs under the current TEFRA system.

Comment: A commenter questioned the exclusion of the continuous improvement bonus payments when computing budget neutrality since these bonus payments have been a part of the TEFRA payment methodology.

Response: Under section 1886(b)(2) of the Act, a hospital that has been excluded from the inpatient prospective payment system for at least three full cost reporting periods prior to the subject period and whose operating costs per discharge for the subject period are below the lower of its target amount, trended costs, or expected costs for the subject period, is eligible for a continuous improvement bonus payment. The statute defines expected costs as the lesser of the operating costs or the target amount for the previous cost reporting period updated by the market basket. The amount of the continuous improvement bonus payment is equal to the lesser of—(1) 50 percent of the amount by which operating costs were less than the expected costs for the period, or (2) one percent of the ceiling.

In the determination of continuous improvement bonus payments in accordance with § 413.40(d)(5), we compare actual operating costs incurred in the current period with the expected costs that are based on cost incurred in the prior period. Since the latest cost report information available is from FY 1999 (and in some cases FY 1998), it was necessary for us to use those reported costs and the applicable market basket increases to estimate both the costs incurred in the current period (FY 2003) and the costs incurred in the prior period (FY 2002). We used the same cost data and market basket increases to estimate current year (FY 2003) operating costs and expected costs updated to FY 2003. Therefore, the operating costs in FY 2003 would always be equal to (never less than) the expected costs for FY 2003. In the continuous improvement bonus calculation, we subtract current operating costs from expected costs and multiply this difference by a percentage as specified in § 413.40(d)(5). Accordingly, this would result in no continuous improvement bonus for these hospitals in FY 2003. Therefore, continuous improvement bonus payments are not considered in determining budget neutrality.

Step 3: Determine each LTCH's payment for capital-related costs.

Under the TEFRA system, in accordance with section 1886(g) of the Act, Medicare allowable capital costs are paid on a reasonable cost basis. Thus, each LTCH's payment for capital-related costs will be taken directly from the cost report and updated for inflation using the excluded hospital market basket, consistent with the methodology used under the IRF prospective payment system. As we discussed previously in this section, as a result of the qui tam action involving some LTCHs, we adjusted those affected LTCHs' cost report data by a factor equal to the amount of the settlement attributable to that LTCH during that specific cost reporting period divided by the total payments received by that LTCH during that cost reporting period.

Comment: Some commenters stated that there is a discrepancy between the capital-related costs per discharge reported in the LTCH rate-setting files posted on the CMS website, and the capital costs reported on the Medicare cost reports that were used to develop the proposed payment rates. The commenters asserted that while we have stated in Part 8.2 of the ''Questions and Answers'' posted on the website that the capital-related costs were identified from the Minimum Data Sets (MDS) using worksheet D, Part I for routine capital costs, and worksheet D, Part II for ancillary capital costs, some hospitals' capital-related routine service costs were instead reported on worksheet D–1, Part II (column 1, lines 50, 51, and 52). Since none of these hospitals had teaching programs and none were subject to the qui tam adjustment, these costs were entirely capital-related. The commenter stated that this discrepancy on the MDS seems to have understated capital-related costs for 64 of the 211 LTCHs used in the proposed rule in the calculation of the proposed standard Federal rate by approximately 2 percent (resulting in an estimated increase in base payments of $40 million).

Response: We have reviewed the lines on Worksheet D, Parts I and II, and Worksheet D–1, Part II on the HCRIS MDS and have found that, in fact, there are a number of LTCHs that have not reported capital-related costs on Worksheets D, Parts I and II, but have reported these costs on Worksheet D–1, Part II, column 1, lines 50, 51, and 52. Therefore, the commenter is correct in assuming that since only capital-related costs from Worksheets D, Parts I and II were identified in our base rate calculations, capital-related costs were underestimated in the calculation of the standard Federal rate. These costs were originally excluded from our calculations because these hospitals did not properly report these costs on their cost reports. The cost report instructions direct hospitals, including hospitals excluded from the acute care hospital inpatient prospective payment system, to report their capital-related costs, not only on Worksheet D–1, Part II, but also on Worksheets D, Parts I and II. However, because we have been made aware that LTCHs have reported capital-related costs on Worksheet D–1, Part II, we have revised our rate calculations to account for these costs. Thus, for this final rule, we determined capital-related costs using data from Worksheets D, Parts I and II and Worksheet D–1, Part II.

Comment: A commenter asked how the average capital costs per case were calculated from the cost report variables for the proposed rule.

Response: Similar to the calculation of average operating costs per case discussed in step 2 above, we determined the average capital cost per case by dividing total Medicare inpatient capital costs for the same cost reporting period from worksheets D, Part I and Part II and Worksheet D–1, Part II by the total number of Medicare discharges for the cost reporting period from worksheet S–3.

Step 4: Determine each LTCH's average total (operating and capital) payment per case under the current (TEFRA) payment system.

In the proposed rule and for this final rule, once estimated payments for inpatient operating costs are determined (including bonus and relief payments, as appropriate), we added the operating payments and capital payments together to determine each LTCH's estimated total payments under the current (TEFRA) payment system. We then divide each LTCH's estimated total TEFRA payments by the corresponding number of Medicare discharges from the cost report to determine what each LTCH's average total payment per case would be under the current (TEFRA) payment system.

Step 5: Determine a case weighted average payment under the current (TEFRA) payment system.

For both the proposed rule and this final rule, we determined each LTCH's average payment under the current (TEFRA) system weighted for its number of cases in the March 2002 update of the FY 2001 MedPAR file by multiplying its average total payment per case from step 4 by its number of cases in the FY 2001 MedPAR file.

Step 6: Estimate total (MedPAR) weighted payments under the current (TEFRA) payment system.

In the proposed rule and for this final rule, we estimated total weighted payments under the current (TEFRA) payment system by summing each LTCH's (MedPAR) weighted payments under the current (TEFRA) payment system (from step 5). In addition, we adjusted the estimated total weighted payments to reflect the estimated portion of additional outlier payments under § 412.525(a). (This is consistent with not including outlier payments in estimating payments under the prospective payment system in Step e. below.) This total is the numerator in the calculation of a budget neutrality adjustment.

d. Calculate the average weighted payment per discharge amount.

Once estimated total payments under the current payment system are calculated, we calculated an average per discharge payment amount weighted by the number of Medicare discharges under the current payment system. This is done by first determining the average payment per discharge amount under the current payment system for each LTCH. Cost report data is used to calculate each LTCH's average payment per discharge by dividing the number of discharges into the total payments. As explained in section X.K.2.a. of this final rule, if applicable, the LTCH's payment per discharge is adjusted consistent with the terms of the DOJ settlement agreement.

Next, we determined the weighted average per discharge payment amount by multiplying each LTCH's average payment per discharge amount from the cost report by the number of discharges from the Medicare claims data in the FY 2001 MedPAR files. Then we added the amounts for all LTCHs and divided by the total number of discharges from the Medicare claims in the FY 2001 MedPAR files to derive a weighted average payment per discharge.

e. Estimate payments under the prospective payment system without a budget neutrality adjustment.

Payments under the payment system are then estimated without a budget neutrality adjustment. In the proposed rule (67 FR 13471), we stated that to do this, we would multiply each LTCH's case-mix index adjusted for short-stay outliers by the number of discharges from the Medicare claims in MedPAR files adjusted for short-stay outliers and the weighted average per discharge payment amount computed above. As we clarify below, this statement did not reflect the actual methodology used in either the proposed or final rules.

Comment: One commenter asked about the variable ''Prospective Payment System Payments (Excluding Outlier Payments)'' used in the rate-setting file posted on the website. This variable is described as ''Estimate of payments under the proposed LTCH prospective payment system for cases in the FY 2000 MedPAR by applying the proposed payment methodologies for very short-stay discharges and short-stay outliers, but excluding outlier payments.'' The commenter wanted to know whether the method used to determine this variable was—(1) applied to proposed payment methodologies for very short-stay discharges and short-stay outliers or (2) used the variable ''Number of Equivalent MedPAR Cases'' and the variable ''Case Mix Index''.

Response: In the rate-setting file and in Step e. described in the proposed rule (67 FR 13471), we actually estimated prospective payment system payments for each provider by simulating payments on a case-by-case basis by applying the proposed payment methodologies for very short-stay discharges and short-stay outliers to the case-specific discharge information from the MedPAR files. Thus, the variable ''Prospective Payment System Payments (Excluding Outlier Payments)'' in the rate-setting file was determined by applying proposed payment methodologies for proposed very short-stay discharges and short-stay outliers. However, a reasonable estimate of prospective payment system payments under the proposed LTCH prospective payment system can be determined by using the variable ''Number of Equivalent MedPAR Cases'' and the variable ''Case-Mix Index'' in the rate-setting file, which was adjusted for short-stay outliers by counting them as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay of the LTC–DRG for nonshort-stay outlier cases. This ''proxy'' using the fractional adjustment for short-stay outliers was not used to determine the payment for those cases in determining estimated total prospective payment system payments in the rate-setting file or in the determination of the proposed standard Federal rate since, as we explained above, we actually estimated prospective payment system payments on a case-by-case basis.

For this final rule, as we explained above for the proposed rule, we estimated prospective payment system payments for each provider by simulating payments on a case-by-case basis by applying the final payment policy for short-stay outliers (as described in section X.C. of this preamble) and the final adjustments for differences in area wages (as described in section X.J.1. of this preamble) and cost-of-living for Alaska and Hawaii (as described in section X.J.5. of this preamble) to the case-specific discharge information from the FY 2001 MedPAR files.

For purposes of this calculation, we simulated case-by-case payments for each LTCH as if it were paid based on 100 percent of the standard Federal rate in FY 2003 rather than the transition blend methodology described in section X.K.2.h. of this final rule. Total payments for each LTCH are summed for all LTCHs. This total is the denominator in the calculation of the budget neutral adjustment.

f. Determine the budget neutrality adjustment.

For this final rule and as we discussed in the proposed rule, the budget neutrality adjustment is calculated by dividing total adjusted payments under the current payment system (the total amount calculated in section X.K.2.c. of this preamble) by estimated payments under the prospective payment system, without a budget neutrality adjustment (the total amount calculated in section X.K.2.e. of this preamble).

g. Determine the standard Federal payment rate.

For this final rule and as we explained in the proposed rule, the resulting budget neutrality adjustment (determined in section X.K.2.f. of this preamble) is then multiplied by the average weighted per discharge payment amount under the current payment system and we adjusted the result further to include a behavioral offset. As previously stated, to calculate the standard Federal payment rate, we estimated what would have been paid under the current payment system. However, we expect that as a result of the implementation of the new prospective payment system, LTCHs may experience usage patterns that are significantly different from their current usage patterns. Since there is a fixed payment based on diagnosis in a per discharge prospective payment system

regardless of the length of stay (except for additional outlier payments), there will be an incentive to discharge a patient (to home or to another site of care) as early in the stay as possible in order to minimize cost and maximize profit. As a result, discharges may occur earlier in the LTCH stay. This will result in lower payments under the current prospective payment system for this care that must be taken into account when computing the budget neutral payment rate. Furthermore, as explained in sections X.A.2. and K. of this preamble, we expect the LTCH's coding practice of LTCHs to improve once the prospective payment system is implemented, which has a significant potential of resulting in a case-mix that will be higher than what would be used to determine the budget-neutral standard Federal rate.

As was the case when the hospital inpatient prospective payment system was implemented, improved coding could result in a higher case-mix because hospitals will code secondary diagnoses more completely and accurately, now that these diagnoses are factored into the LTC–DRG assignment and, ultimately, their payment. The inclusion of appropriate secondary diagnoses could result in the case being grouped into a higher weighted LTC–DRG. This is especially true for LTCHs since they generally treat more medically complex patients who are more likely to have many secondary diagnoses. Thus, if the same cases that were used to develop the standard Federal rate are grouped into higher weighted LTC–DRGs as a result of improved coding, this higher case-mix will result in higher payments under the payment system for this care. This effect must also be taken into account when computing the budget neutral standard Federal rate. Accounting for these effects through an adjustment is commonly known as a behavioral offset.

The proposed standard Federal payment rate with a behavioral offset was $27,649.02, which included the proposed 0.27 percent reduction for the behavioral offset. As we explained in the proposed rule, consistent with the assumptions made under the IRF prospective payment system, in determining the proposed (and final) behavioral offset adjustment, we assumed that the LTCHs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with the LTC–DRG at any point.

Comment: One commenter was concerned about the proposed 0.27 percent reduction for the behavioral offset to the proposed standard Federal rate. The commenter stated that no credible data was identified to support this number. The commenter contended that CMS should consider the budgetary impact of the migration of patients from the IRF setting to the LTCH setting, given the growing number of rehabilitation cases admitted to LTCHs and the significant increase in the reimbursement for these services in LTCH settings as compared to IRF settings. The commenter also recommended that the behavioral offset used for LTCHs should be adjusted to be consistent with the behavioral offset of the IRF prospective payment system (1.16 percent), and that the budget neutrality adjustment should be recalculated. The commenter suggested that this would serve to ensure that there is no improper payment incentive for treating rehabilitation patients in a LTCH rather than at lower cost in an IRF.

Response: We believe that we utilized the best data available to develop the proposed behavioral offset. Consistent with the IRF prospective payment system, and as we explained in the proposed rule, in our actuarial model we assumed that LTCHs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with the LTC–DRG at any point. In an effort to be as consistent as possible with the IRF prospective payment system, we used the same assumptions (described above) that we used to calculate the behavioral offset for the IRF prospective payment system. We used the same assumptions because, as the commenter noted, there are parallels between IRFs and LTCHs, and, absent any convincing data to the contrary, we believe these hospitals would react similarly to similar incentives. The difference in the behavioral offsets (that is, 1.16 percent for IRF prospective payment system and the proposed 0.27 percent for the proposed LTCH prospective payment system) is due to the different numbers of LTCHs and IRFs and the differences in the distribution of losses and gains for the respective hospitals under each prospective payment system.

Based on the commenter's recommendation to reevaluate the methodology we used to determine behavioral offset, we took into consideration the increases to the hospital-specific target amounts and cap on the target amounts for LTCHs provided for by section 307(a)(1) of the BIPA and the enhanced bonus payments for LTCHs for FY 2001 and FY 2002 provided for by section 122 of the BBRA. As a result, based on updated data, the standard Federal payment rate in this final rule includes a behavioral offset of 0.34 percent. As we explained in the proposed rule, consistent with the methodology used under the IRF prospective payment system, in determining the behavioral offset, we assumed that LTCHs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with the LTC–DRG at any point. The final standard Federal payment rate is $34,956.15 for FY 2003. This dollar amount includes a 0.34 percent (that is, thirty-four hundredths of one percent) reduction for the behavioral offset in the standard Federal payment rate otherwise calculated under the methodology described above.

h. Determine a budget neutrality offset to account for the transition methodology.

Section 123(a)(1) of the BBRA requires that the LTCH prospective payment system maintain budget neutrality. As discussed in further detail in section X.N. of this preamble, we are implementing a 5-year transition period from cost-based TEFRA reimbursement to prospective payment, during which a LTCH will be paid an increasing percentage of the LTCH prospective payment system rate and a decreasing percentage of its TEFRA rate for each discharge. Furthermore, we will allow a LTCH to elect to be paid based on 100 percent of the standard Federal rate in lieu of the blend methodology.

Based on a comparison of the estimated FY 2003 payments to each LTCH based on 100 percent of the proposed standard Federal rate and the proposed transition blend methodology, in the proposed rule (67 FR 13472), we projected that approximately 58 percent of LTCHs would elect to be paid based on 100 percent of the proposed standard Federal rate since they would receive higher payments than under the proposed transition blend methodology. We also projected that the remaining 42 percent of LTCHs would choose to be paid based on the proposed transition blend methodology (80 percent of TEFRA; and 20 percent of the prospective payment system) in FY 2003 since they would receive higher payments than if they were paid based on 100 percent of the proposed Federal rate.

Comment: One commenter observed that since many of its hospitals included in the rate-setting file posted on CMS' website are projected to have total LTCH prospective payments in excess of total TEFRA payments for FY 2003, these

LTCHs would be included in the 58 percent of LTCHs that CMS expects would elect to be paid immediately based on 100 percent of the proposed standard Federal rate in the first year of the proposed transition period. The commenter noted that its LTCHs have cost reporting periods that run from September to August, and concluded that hospitals would be able to transition to the full Federal rate regardless of when their cost reporting period begins. The commenter stated that otherwise, its hospitals would not be able to elect payment based on to the full Federal rate until September 1, 2003, thereby making the 58-percent assumption too high. The commenter added that, since CMS specified in the proposed rule that one of CMS's ''goals is to transition hospitals to full prospective payments as soon as appropriate'' (67 FR 13474), this supports the conclusion that hospitals would be able to elect payment based on the full Federal rate during the proposed transition period regardless of their cost reporting years.

Response: The commenter is incorrect that LTCHs would be able to transition immediately on October 1, 2002, to payment based on the full Federal rate, regardless of when their next cost reporting period begins. As we stated in the proposed rule (67 FR 13473), ''the transition period for all hospitals subject to the proposed LTCH prospective payment system would *begin with the hospitals' first cost reporting period beginning on or after October 1, 2002* and extend through the hospitals' last cost reporting period beginning before October 1, 2007'' (emphasis added). In addition, in the proposed rule (67 FR 13474), we stated, ''In implementing the proposed prospective payment system for LTCHs, one of our goals is to transition hospitals for full prospective payments as soon as appropriate. Therefore, we are proposing under § 412.533(b), to allow a LTCH to elect payment based on 100 percent of the Federal rate at the *start* of any of its cost reporting periods during the 5-year transition period rather than incrementally shifting from cost-based payments to prospective payments' (emphasis added). Thus, a LTCH must wait until its cost reporting period that *begins during FY 2003* to elect payment based on the full Federal rate. This means that the commenter's LTCHs, many of which have cost reporting periods that begin on September 1, would have to wait until September 1, 2003, to transition to payments based on the full Federal rate. Before their cost reporting period that begins during FY 2003, the LTCHs would continue to receive payment under the TEFRA methodology. Accordingly, in the proposed rule when we estimated that 58 percent of all LTCHs would elect to be paid based on 100 percent during FY 2003, we accounted for our proposed policy that would require a LTCH to wait until the beginning of its cost reporting period beginning on or after October 1, 2002, to elect payment based on the full proposed Federal rate.

In this final rule, for FY 2003, using the same methodology described in the proposed rule, based on updated data, we project that approximately 49 percent of LTCHs will elect to be paid based on 100 percent of the standard Federal rate rather than receive payment on the transition blend methodology. Using the same methodology described in the proposed rule, this projection, which uses updated data and inflation factors, is based on our estimate that LTCHs would receive higher payments based on 100 percent of the standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we project that the remaining 51 percent of LTCHs will choose to be paid based on the transition blend methodology (80 percent of TEFRA; and 20 percent of the prospective payment system) in FY 2003 since they would receive higher payments than if they were paid based on 100 percent of the standard Federal rate.

As we discuss in section X.K.2.g. of this preamble, the standard Federal rate ($34,956.15) is determined as if all LTCHs will be paid based on 100 percent of the standard Federal rate in FY 2003. Since we are implementing a 5-year transition period (section X.N. of this preamble) in order to maintain budget neutrality, as we described in the proposed rule, we will reduce all LTCH Medicare payments during the transition period by a factor, which is equal to 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would have been made if the LTCH prospective payment system had not been implemented, to the projected total Medicare program prospective payment system payments (that is, payments made under the transition methodology and the option to elect payment based on 100 percent of the Federal rate as described in section X.N. of this preamble).

In the March 22, 2002 proposed rule, we projected that the full effect of the 5-year transition period and the election option would result in a cost to the Medicare program of $230 million as follows: For FY 2003, $50 million; for FY 2004, $80 million; for FY 2005, $60 million; for FY 2006, $30 million; for FY 2007, $10 million.

Thus, in order to maintain budget neutrality, we proposed to apply a 5.1 percent reduction (0.949) to all LTCHs' payments in FY 2003 to account for the estimated cost of $50 million for FY 2003. Furthermore, in order to maintain budget neutrality, we indicated that in the future we would propose a budget neutrality offset for each of the remaining years of the transition period to account for the estimated costs for the respective fiscal year.

In this final rule, based on the latest available data, the policy revisions described, and the effect of the increase to the hospital target amounts and caps on the target amounts provided for under section 307(a)(1) of BIPA, we project that the full-effect of the 5-year transition period and the election option will result in a cost to the Medicare program of $240 million as follows:

Fiscal year	Estimated cost (in millions)
2003	$50
2004	80
2005	60
2006	40
2007	10

Therefore, in this final rule, we are applying a 6.6 percent reduction (0.934) to *all* LTCHs' payments in FY 2003 to account for the estimated cost of the $50 million for FY 2003.

Comment: Some commenters were concerned that CMS' projected costs of LTCHs transitioning to payment based on 100 percent of the standard Federal rate in FY 2003 are incorrect and need to be clarified. The commenters stated that their calculations indicated that if the proposed 5.1 percent reduction were applied to *all* FY 2003 LTCH payments, it would result in a reduction of more than $90 million, which is more than double what is required to maintain budget neutrality. Other commenters similarly stated that they calculated that CMS will actually reduce payments by approximately $94 million, rather than the estimated $50 million. These commenters proposed that Medicare ensure budget neutrality by neither underpaying nor overpaying LTCHs. Specifically, the commenters asked that CMS clarify how a $50 million cost to the Medicare program equates with the proposed 5.1 percent reduction to maintain budget neutrality at $1.8 billion. The commenters also inquired as to whether both the LTCH prospective payments system and the cost-based portions of the proposed transition blend methodology payments

in FY 2003 are to be reduced by the proposed 5.1 percent.

Response: In the March 22, 2002 proposed rule, based on a comparison of the estimated FY 2003 payment to each LTCH based on 100 percent of the proposed standard Federal rate versus the proposed transition blend methodology, we projected that approximately 58 percent of LTCHs would elect to be paid based on 100 percent of the proposed standard Federal rate since they would receive higher payments than under the proposed transition blend methodology. We projected that the cost of 58 percent of LTCHs transitioning during FY 2003 to 100 percent of the proposed standard Federal rate would be $50 million. Since the proposed standard Federal rate of $27,649.02 was calculated as if all LTCHs would be paid based on 100 percent of the proposed standard Federal rate in FY 2003, in order to maintain budget neutrality, we proposed to reduce *all* LTCH Medicare payments by 5.1 percent (that is, *both* the prospective payment portion *and* the cost-based portion of the proposed transition blend methodology). Thus the proposed 5.1 percent reduction would be applied to *all* LTCH payments, regardless of whether the LTCH is being paid based on 100 percent of the proposed standard Federal rate or the transition blend methodology. The proposed reduction in payments to all LTCHs was considered in maintaining budget neutrality at $1.8 billion.

The commenters expressed concern that our projected costs of LTCHs transitioning to payment based on 100 percent of the proposed standard Federal rate in FY 2003 are incorrect and need to be clarified. In the proposed rule, program payments for LTCH services were estimated to be $1.8 billion in FY 2003. Since the proposed standard Federal rate was calculated as if all LTCHs would be paid based on 100 percent of the proposed standard Federal rate in FY 2003, without the proposed 5.1 percent reduction, payments would increase from $1.800 billion to $1.892 billion because of those LTCHs that in FY 2003 would be paid based on the transition blend methodology (that includes 80 percent of TEFRA payments) rather than receive payments based on 100 percent of the proposed standard Federal rate.

As stated above, since a LTCH must wait until the *start* of its cost reporting period that begins in FY 2003 before transitioning to payment based on 100 percent of the standard Federal rate, the actual amount of projected LTCH payments for all cost reporting periods that begin during FY 2003 (that is, for complete 12-month periods) is $92 million. Dividing $92 million by $1.8 billion yields 5.1 percent. This was the percent reduction that we proposed to apply to all LTCH payments made in cost reporting periods beginning during FY 2003. However, since the $92 million includes payments made for portions of cost reporting periods extending beyond FY 2003, it was reduced to represent only the portion of LTCH prospective payments made *during* FY 2003 (that is, payments between October 1, 2002 and September 30, 2003). Accordingly, to account for the portion of LTCH payments that were estimated to be made based on 100 percent of the Federal rate during FY 2003, the projected cost of $92 million based on complete cost reporting periods was reduced to $60 million based on an analysis of LTCH costs incurred by each LTCH for the portion of its cost reporting period that will occur during FY 2003. For example, for a LTCH with a July 1st cost report begin date, only the projected costs for July 1, 2003 through September 30, 2003 were used.

Finally, since LTCH payments for some services provided during FY 2003 may not be made until FY 2004 (for example, a patient may be treated in a LTCH in September 2003, but payment may not be made by Medicare under the LTCH prospective payment system until October 2003, which is during FY 2004), the cost of $60 million was further reduced to $50 million based on an analysis of LTCH discharges occurring in each LTCH for the portion of its cost reporting period that will occur during FY 2003. For example, for a LTCH with a July 1st cost report begin date, only those discharges projected to occur from July 1, 2003 through September 30, 2003 were considered. Thus, in the proposed rule, $50 million represented the estimated costs that the Medicare program was projected to incur for LTCH prospective payments (based on 100 percent of the proposed standard Federal rate) made during FY 2003 (that is, payments between October 1, 2002 and September 30, 2003). We note that the same methodology was also employed in this final rule to determine the 6.6 percent reduction to all LTCH payments in FY 2003.

Comment: One commenter was ''troubled'' by our assumption that all hospitals whose payments would increase based on 100 percent of the Federal rate would in fact act appropriately and notify their fiscal intermediary prior to the commencement of the prospective payment system in order to qualify for payment at 100 percent of the Federal rate. The commenter asserted that in order for this to happen, more than 150 (58 percent of 270) LTCHs would, without exception, accurately analyze the financial impact of the LTCH prospective payment system, take appropriate action to make the election to 100 percent of the Federal rate, and do so prior to 30 days of the onset of the LTCH prospective payment system. The commenter believed that the number of hospitals that elect payment based on the Federal rate would be far fewer than anticipated. The commenter added that there may be other reasons why a LTCH which may have been projected to gain reimbursement by moving immediately to the full prospective payment system may choose not to make the election.

Response: Our estimate in the proposed rule that 58 percent of LTCHs will choose to be paid based on 100 percent of the proposed standard Federal rate beginning in FY 2003 was based on the best data that we had available at that time. We note that, as we move through the initial years of implementation, we will make any necessary adjustments to maintain budget neutrality. In addition, just as a LTCH that is projected to gain reimbursement by opting for payment based on 100 percent of the Federal rate may have reasons why it would not make this election, the same may be true for LTCHs that are projected to do better under the transition blend, yet for some reason choose to be paid 100 percent under the LTCH prospective payment system. We have also clarified in section X.N. of this preamble that to elect to be paid based on 100 percent of the Federal rate for cost reporting periods that begin on or after October 1, 2002 through November 30, 2002, a LTCH must notify its fiscal intermediary in writing of this election by before November 1, 2002, not 30 days prior to the start of its next cost reporting period.

Comment: One commenter recommended that the proposed 5.1 percent reduction be applied only to those LTCHs that choose to be paid on the proposed transition blend methodology. Another commenter suggested that, instead of applying the proposed 5.1 percent reduction to all LTCH prospective payment system payments based solely on the assumption that 58 percent of all existing LTCHs will opt to go immediately to payment based on 100 percent of the proposed standard Federal rate, CMS should make annual adjustments to account for actual experience.

Response: Under section 123 of Public Law 106–113 and section 307 of Public Law 106–554, the Secretary has broad

authority to develop the LTCH prospective payment system. Under this authority, as we discuss in section X.N. of this preamble, effective for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, we are providing LTCHs with the option to be paid either under the transition blend methodology or under the LTCH prospective payment system. In other words, a LTCH may elect to be paid on 100 percent of the unadjusted standard Federal rate at the start of its cost reporting period during the 5-year transition period specified in § 412.533(a). We do not believe that it is appropriate for LTCHs in either category (that is, LTCHs that elect to receive payment based on 100 percent of the Federal rate or LTCHs that are paid under the transition blend) to solely bear the costs of the 5-year transition methodology. Rather, we believe that it is more equitable for all LTCHs to fund the costs of transitioning to the new LTCH prospective payment system. Therefore, we proposed to apply the 5.1 percent reduction to all LTCHs for cost reporting periods beginning during FY 2003. Accordingly, for this final rule, we are applying the revised percent reduction of 6.6 percent (1 − 0.934) to *all* LTCH payments for cost reporting periods beginning during FY 2003. This adjustment is being made based on an estimate of the number of LTCHs that will elect to be paid at 100 percent of the Federal rate. Since this is a prospective payment system with prospectively determined payment rates, we do not agree with the commenter that it would be appropriate to make the adjustment based on subsequent actual data on the number of hospitals that make the election.

As we explained in the proposed rule (67 FR 13472), based on the data available at that time, we stated in the proposed rule that we would propose the following budget neutrality offsets to LTCH payments during the transition period: 3.9 percent (0.961) in FY 2004; 2.6 percent (0.974) in FY 2005; and 1.3 percent (0.987) in FY 2006. Based on the updated data available at this time, using the same methodology described in the proposed rule, we estimate the budget neutrality offsets to LTCH payments during the remainder of the transition period would be 5.0 percent (0.950) in FY 2004; 3.4 percent (0.996) in FY 2005; and 1.7 percent (0.983) in FY 2006. No budget neutrality offset is necessary in the 5th year of the transition period (FY 2007) because under the transition methodology (described in section X.N. of this preamble), all LTCHs will be paid based on 100 percent of the standard Federal rate and zero percent of payments under TEFRA. These estimates are based on the inflation factors and projected Medicare spending for LTCHs discussed in section XII.6. of this final rule, and that an estimated 49 percent of LTCHs will elect to be paid based on 100 percent of the standard Federal rate rather than the transition blend.

As we discussed in the proposed rule, consistent with the statutory requirement for budget neutrality, we intend for estimated aggregate payments under the LTCH prospective payment system to equal the estimated aggregate payments that would be made if the LTCH prospective payment system would not be implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the best available data and necessarily reflects assumptions. When the LTCH prospective payment system is implemented, we will monitor payment data and evaluate the ultimate accuracy of the assumptions used to calculate the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH prospective payment system, as discussed in section X.K. of this final rule). To the extent these assumptions significantly differ from actual experience, the aggregate amount of actual payments may turn out to be significantly higher or lower than the estimates on which the budget neutrality calculations are based.

As we discussed in the proposed rule, section 123 of Public Law 106–113 and section 307 of Public Law 106–554 provide the Secretary broad authority in developing the LTCH prospective payment system, including the authority for appropriate adjustments. Under this broad authority, in this final rule at § 412.523(d)(3), we have provided for the possibility of making a one-time prospective adjustment to the LTCH prospective payment system rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH prospective payment system would not be perpetuated in the prospective payment system rates for future years. (We note that in other contexts (for example, outlier payments under the hospital inpatient prospective payment system) differences between estimated payments and actual payments for a given year are not built into the prospective payment system rates for subsequent years. However, the statutory ratesetting scheme under the LTCH prospective payment system is very different than in other contexts.)

Comment: Some commenters questioned our proposal to make a one-time prospective adjustment to the LTCH prospective payment system rates for unanticipated costs incurred in the first year of implementation in order to maintain budget neutrality. The commenters believed that such a retrospective reconciliation would undermine predictability and stability of the LTCH prospective payment system, and does not appear to have been used by CMS previously or authorized by the Congress. The commenters also stated that we had not outlined any procedures for differentiating spending increases that are warranted and in the best interest of Medicare patients from increases that resulted from mistaken assumptions made by our actuaries. The commenters asked that we abandon this proposal, or at a minimum, provide that it will adjust payments upward if post-prospective payment system LTCH expenditures do not meet the levels projected.

Other commenters opposed our proposal to use a one-time reconciliation. They believed that we should be able to predict, with reasonable certainty, the number of LTCHs that will elect to move directly to the full Federal rate since it would be rational for any lower costs LTCHs to forego this option. The commenters recommended that we go through normal rulemaking prior to making any downward adjustments to any rates, ''because any such adjustment would be vulnerable to budgetary pressures of the moment.''

Response: We understand the commenters' concerns, but we note that section 123 of Public Law 106–113 and section 307 of Public Law 106–554 provide the Secretary broad authority to develop the LTCH prospective payment system, including the authority for appropriate adjustments. Under this authority, we proposed a possible one-time prospective adjustment to the LTCH prospective payment system rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH prospective payments system is not perpetuated in the prospective payment rates for future years. We believe this provision acts to limit either unintended Medicare program savings or unintended spending increases under the LTCH prospective payment system.

When estimating payments for purposes of the budget neutrality calculations, we use the best available

data and any appropriate assumptions. Payment data from the LTCH prospective payment system will be monitored to ensure the ultimate accuracy of the assumptions used to calculate the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH prospective payment system). To the extent that these assumptions significantly differ from actual experience, the aggregate amount of actual payments may turn out to be significantly higher or lower than the estimates on which the budget neutrality calculations are based. Finally, if we determine that changes to the calculation of the rates or budget neutrality are warranted, we will comply with the Administrative Procedure Act in making a one-time adjustment so that the effects of any significant differences between actual payments and estimated payments for the first year of the LTCH prospective payment system are not perpetuated in future years.

In the proposed rule, we estimated that total Medicare program payments for LTCH services over the next 5 years would be $1.80 billion for FY 2003; $1.91 billion for FY 2004; $2.02 billion for FY 2005; $2.14 billion for FY 2006; and $2.26 billion for FY 2007. These estimates were based on most recent estimate of the excluded hospital market basket at that time of 3.6 percent for FYs 2003 through 2005, 3.5 percent for FY 2006, and 3.4 percent for FY 2007, that 58 percent of LTCHs would elect to be paid based on 100 percent of the proposed standard Federal rate rather than the proposed transition blend, and that there would be an increase in Medicare beneficiary enrollment of 2.2 percent in FY 2003, 2.3 percent in FYs 2004 and 2005, 2.4 percent in FY 2006, and 2.3 percent in FY 2007.

In this final rule, based on updated data, we estimate that total Medicare program payments for LTCH services over the next 5 years will be:

Fiscal year	Estimated payments ($ in billion)
2003	$1.59
2004	1.69
2005	1.79
2006	1.90
2007	2.00

These estimates are based on an update of our estimate of FY 2003 payments to LTCHs using our Office of the Actuary's most recent estimate of the excluded hospital market basket of 3.4 percent for FY 2004, 3.5 percent for FY 2005, 3.2 percent for FY 2006, and 2.9 percent for FY 2007, and our Office of the Actuary's projection that there will be an increase in Medicare beneficiary enrollment of 1.8 percent in FY 2004, 1.5 percent in FYs 2005 and 2006, and 1.9 percent in FY 2007.

Comment: One commenter stated that the TEFRA caps for nearly 50 percent of the LTCHs are lower than the proposed standard Federal rate, which may possibly violate budget neutrality. Specifically, the commenter stated that, under the TEFRA system, since the ''new'' provider cap for LTCHs in FY 2002 and the maximum amount of reimbursement that a new LTCH could receive is approximately $24,000, as compared to the proposed standard Federal rate, higher costs may be incurred by the Medicare program under the proposed LTCH prospective payment system. The commenter stated that since it is difficult to accurately project the costs under the LTCH prospective payment system given the limitations of the data, it is not unlikely that budget neutrality will be violated. The commenter recommended that CMS reexamine the relevant data for all LTCHs (including those not included in the rate-setting file) and devise a methodology that takes into account the large number of ''new'' LTCHs and the abnormally high costs associated with ''new'' LTCHs.

Response: We disagree with the commenter that budget neutrality will be violated. We believe the commenter is inappropriately equating the TEFRA target amount to the standard Federal rate. Because the TEFRA payment methodology and the LTCH prospective payment system are fundamentally different systems, budget neutrality must be maintained in the aggregate at total payment levels, not among the various components of the respective systems. Thus, the fact that the TEFRA target amount of $24,000 for new providers is less than the proposed standard Federal rate of $27,649.02 is irrelevant.

While we are aware that there are some limitations to the data, the data that we used were the best data available at the time. As the commenter recommended, we intend to reexamine the LTCH prospective payment system as more data becomes available. However, we want to emphasize that the statute requires that the LTCH prospective payment system must ultimately be budget neutral to total TEFRA payments.

L. Development of the Federal Prospective Payments

Once the relative weights for each LTC–DRG and the standard Federal payment rate are calculated, the Federal prospective payments can be determined. As provided for in this final rule, in accordance with § 412.523(c)(4), a LTC–DRG payment is calculated by multiplying the standard Federal payment rate by the appropriate LTC–DRG relative weight. The equation is as follows:

Federal Prospective Payment = LTC–DRG Relative Weight *Standard Federal Payment Rate

M. Computing the Adjusted Federal Prospective Payments

The Federal prospective payments described in section X.L. of this preamble will be adjusted to account for differences in area wages by multiplying the labor-related share of the unadjusted Federal prospective payment amount (LTC–DRG relative weight × standard Federal rate) by the appropriate LTCH wage index (see section X.J.1. of this preamble). The Federal prospective payments described in section X.L. of this preamble will also be adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the unadjusted Federal prospective payment amount by the appropriate adjustment factor shown in the table in section X.J.5. of this final rule. To illustrate the methodology we are using to adjust the Federal prospective payments, we are providing the following example:

In FY 2003, a Medicare patient is in a LTCH located in Chicago, Illinois (MSA 1600) with a one-fifth wage index value of 1.0202 (see Table 1 in the Addendum to this final rule). The Medicare patient is classified into LTC–DRG 4 (Spinal Procedures), which has a relative weight of 1.2493 (see Table 3 of the Addendum to this final rule). To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted Federal prospective payment amount by multiplying the unadjusted standard Federal rate ($34,956.15) by the labor-related share (72.885 percent) and the wage index (1.0202). This wage-adjusted amount is then added to the nonlabor-related portion of the standard Federal rate (27.115 percent) to determine the wage-adjusted Federal rate, which is multiplied by the LTC–DRG relative weight to calculate the total adjusted Federal prospective payment for FY 2003 ($44,313.67). The following illustrates the components of the calculations in this example:

Unadjusted Federal Prospective Payment Rate	$34,956.15
Labor-Related Share	× 0.72885
Labor-Related Portion of the Federal Rate	= $25,477.79
Wage Index (MSA 1600)	× 1.0202
Wage-Adjusted Amount	= $25,992.44
Nonlabor-Related Portion of the Federal Rate	+ $ 9,478.36
Wage-Adjusted Federal Rate	= $35,470.80
LTC–DRG 4 Relative Weight	× 1.2493
Total (Wage) Adjusted Federal Prospective Payment	= $44,313.67

N. Transition Period

Under the broad authority conferred upon the Secretary by section 123 of Public Law 106–113 for development of a prospective payment system for LTCHs, we are implementing, under § 412.533, a 5-year transition period from reasonable cost-based reimbursement under the TEFRA system to a prospective payment based on industry-wide average operating and capital-related costs. Under the average pricing system, payment will not be based on the experience of an individual hospital. We believe that a 5-year phase-in will provide LTCHs time to adjust their operations and capital financing to the new payment system, which is based on prospectively determined Federal payment rates.

Moreover, capital renovation and expansion plans of certain LTCHs may not be amenable to short-term adjustment due to the commitment of capital funds involved. We believe that a 5-year transition period with an increasing percentage of prospective payments will afford LTCHs an opportunity to increase their efficiency in the delivery of operating services and reserve additional payments to finance their capital expenditures.

We further believe that the 5-year phase-in of the LTCH prospective payment system will allow LTCH personnel to develop proficiency with the LTCDRG coding system, resulting in improvement in the quality of the data used for generating our annual determination of relative weights and payment rates. Our analysis conducted during the development of the LTCH prospective payment system revealed that most patients in LTCHs have several diagnosis codes on their Medicare claims indicating multiple CCs, although further review of individual case studies indicated that in some instances all of the diagnoses were not reported. Since payments to LTCHs under the current TEFRA payment system are based on reasonable costs, not diagnosis codes, past coding by LTCHs may not have accurately reflected the patient's diagnoses. Further evidence of incomplete coding is shown by the pairs of LTCDRGs where the ''without CC'' LTCDRG had a higher average charge than the corresponding with CC LTCDRG. As described in more detail in section IX.D. and E. of this final rule, since the LTCDRGs ''with CCs'' require more coded information, we believe this phenomenon indicates incomplete coding and that over the 5-year phase-in of the LTCDRG-based LTCH prospective payment system, this problem will be resolved.

The 5-year transition period will enable us to collect Medicare claims and cost data that will be produced based on new program instructions to providers and fiscal intermediaries, and subject to program integrity monitoring. This gradual phase-in will provide a stable fiscal base for LTCHs, as we analyze data that may lead to our revisiting and perhaps proposing specific policy revisions to the LTCH prospective payment system.

The transition period for all hospitals subject to the LTCH prospective payment system will begin with the hospital's first cost reporting period beginning on or after October 1, 2002 and extend through the hospital's last cost reporting period beginning before October 1, 2007. During the 5-year transition period, a LTCH's total payment under the prospective payment system will be based on two payment percentages—one based on reasonable cost-based (TEFRA) payments, and the other based on the standard Federal prospective payment rate. The blend percentages are as follows:

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

For a cost reporting period beginning on or after October 1, 2002, and before October 1, 2003, the total payment for a LTCH is 80 percent of the amount calculated under the current (TEFRA) payment system for that specific LTCH and 20 percent of the Federal prospective payment amount. The percentage of payment based on the LTCH prospective payment system Federal rate will increase by 20 percentage points each year, while the TEFRA rate percentage will decrease by 20 percentage points each year, for the next 4 fiscal years. For cost reporting periods beginning on or after October 1, 2006, Medicare payment to LTCHs will be determined entirely under the Federal prospective payment system methodology. The TEFRA rate percentage is a LTCH specific amount that is based on the amount that the LTCH would have been paid (under TEFRA) if the prospective payment system were not implemented.

Medicare fiscal intermediaries will continue to compute the LTCH TEFRA payment amount according to § 412.22(b) of the regulations and sections 1886(d) and (g) of the Act. We note that several TEFRA payment system provisions that currently are in effect will no longer be effective for cost reporting periods beginning in FY 2003. For instance, the caps on the target amounts for ''existing'' LTCHs provided for under section 4414 of the BBA (see § 413.40(c)(4)(iii)) for FYs 1998 through 2002 will no longer be applicable for cost reporting periods beginning in FY 2003. For purposes of the LTCH prospective payment system, a LTCH's target amount for FY 2003 will be determined by updating its FY 2002 target amount, which was subject to the FY 2002 cap. In addition, the 15-percent reduction to payments to LTCHs for capital-related costs provided for under section 4412 of the BBA (§ 413.40(j)) is only applicable for portions of cost reporting periods occurring in FYs 1998 through FY 2002. This reduction is no longer applicable for cost reporting periods beginning in FY 2003. Therefore, the TEFRA portion of a LTCH's payment for capital-related costs during the LTCH prospective payment system transition period is based on 100 percent of its Medicare allowable capital costs.

In implementing the prospective payment system for LTCHs, one of our goals is to transition hospitals to full prospective payments as soon as appropriate. Therefore, under § 412.533(c), we will allow a LTCH to elect payment based on 100 percent of the Federal rate at the *start* of any of its cost reporting periods during the 5-year transition period rather than incrementally shifting from cost-based payments to prospective payments. However, a LTCH must wait until its cost reporting period that begins during FY 2003 to make the election to by-pass the transition blend methodology to begin receiving payment based on 100 percent of the Federal rate. Furthermore, once a LTCH elects to be paid based on 100 percent of the Federal rate, it will not be able to revert to the transition blend.

The purpose of the transition period is to allow for a smooth transition from cost-based reimbursement to prospective payment. We believe that it is not appropriate to allow a LTCH to revert back to the blended transition methodology once it elects payment based on 100 percent of the Federal rate because allowing LTCHs to switch back undermines the purpose of transitioning to a fully Federal prospective payment system, as well as being administratively burdensome to our fiscal intermediaries.

In the proposed rule, we stated that, consistent with transition methodology policies under the IRF prospective payment system, in order to elect payment based on 100 percent of the Federal rate, a LTCH must notify the fiscal intermediary of the election no later than 30 days before the beginning of the cost reporting period in the applicable fiscal year beginning on or after October 1, 2003 and before October 1, 2007 (§ 412.533(b)).

Comment: Some commenters are concerned that there will be insufficient time for the submission of notification to elect to be paid on a full Federal rate instead of the transition blend method. Under the proposed rule, the election had to be made no later than 30 days before the beginning of the hospital's cost reporting period in each applicable fiscal year beginning on or after October 1, 2002. Several commenters were concerned that this could prove to be an impossibility depending on the date that this final rule is published. One commenter recommended that the notification should be within a 45-day period of the publication of the final rule, providing a LTCH with sufficient time to notify the fiscal intermediary, as well as to ensure that the hospital is aware of the published LTCH provisions. Another commenter requested a grace period to allow hospitals that have fiscal years beginning at or close to October 1, 2002 additional time to give notice to the fiscal intermediary. One commenter requested clarification regarding when the election to be paid under the full Federal rate may be made. Another commenter pointed out that the use of October 1, 2003 in proposed § 412.533(b)(1) rather than October 1, 2002 in the regulation causes confusion. Apparently, it is not clear if LTCHs may elect to be paid at 100 percent of the Federal rate for cost reporting periods beginning on or after October 1, 2002, but before October 1, 2003.

Response: In response to the comment concerning the ability of a LTCH with a cost reporting period that begins on October 1 to elect payment based on 100 percent of the Federal rate 30 days prior to October 1, 2002, we acknowledge that we inadvertently did not explain the steps a LTCH would undertake in order to elect immediate transition to the full prospective payment system. Specifically, those LTCHs with cost reporting periods that begin on October 1, 2002, and that want to elect to be paid immediately based on 100 percent of the Federal rate may not have sufficient time to notify their fiscal intermediary of their election 30 days prior to October 1, 2002. In this final rule, we are clarifying that LTCHs will have at least 60 days from the publication of this final rule to notify their fiscal intermediary of that election. Accordingly, we are revising § 412.533(c)(2)(ii) to state that for cost reporting periods that begin on or after October 1, 2002 and through November 30, 2002, a LTCH must notify its fiscal intermediary of this election in writing before November 1, 2002. For cost reporting periods beginning on or after December 1, 2002 and for the remainder of the 5-year transition period, the notification of this election must be received by the fiscal intermediary in writing within 30 days prior to the start of the LTCH's next cost reporting period. For example, a LTCH with a cost report period beginning on October 15, 2002, must notify its fiscal intermediary in writing of this election before November 1, 2002, while a LTCH with a cost reporting period beginning on January 1, 2003 must notify its fiscal intermediary in writing of this election before December 2, 2002.

The notification by the LTCH to make the election must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the specified date (that is before November 1, 2002 for cost reporting periods that begin on or after October 1, 2002 through November 30, 2002 or before the 30th day before the applicable cost reporting period begins for cost reporting periods beginning on or after December 1, 2002) regardless of any postmarks or anticipated delivery dates. Notifications received, postmarked, or delivered by other means after the specified date will not be accepted. If the specified date falls on a day that the postal service or other delivery sources are not open for business, the LTCH will be responsible for allowing sufficient time for the delivery of the request before the deadline. If a LTCH's notification is not received, payment will be based on the transition period rates.

Comment: Some commenters urged us to allow a LTCH to elect payment based on 100 percent of the Federal rate beginning with discharges occurring on or after October 1, 2002 without regard to the beginning of the hospital's cost-reporting year if its TEFRA limit is below the 75th percentile cap established for pre-1997 LTCHs. In other words, the commenter requests that we allow a LTCH that has a TEFRA limit below the 75th percentile cap established for pre-1997 LTCHs to elect to receive payment based on 100 percent of the Federal rate for the part of its cost reporting period that begins before October 1, 2002.

Response: In accordance with section 123 of Public Law 106–113, the LTCH prospective payment system will be effective beginning with a hospital's first cost reporting period that begins on or after October 1, 2002. Therefore, we are not adopting the commenters' suggestion to allow a LTCH that has a TEFRA limit below the 75th percentile cap for pre-1997 LTCHs to elect payment based on 100 percent of Federal rate beginning with discharges occurring on or after October 1, 2002. In accordance with § 412.500(b), LTCHs must wait until their first cost reporting period that begins on or after October 1, 2002 to start receiving payments under the LTCH prospective payment system, including the election of payments based on 100 percent of the Federal rate as provided for in § 412.533(c).

Comment: Several commenters requested that, even though BIPA mandates that a default LTCH prospective payment system based on existing DRGs be implemented if the Secretary is unable to implement by October 1, 2002, the proposed rule should be modified and become effective by October 1, 2002. The commenters argued that the system should be ''deemed'' as implemented on that date with appropriate retroactive payment adjustments and that a default system should not be implemented as an interim step.

Response: With the publication of this final rule, we are meeting the statutory October 1, 2002 effective date of the LTCH prospective payment system. Therefore, the comment will not be addressed in this final rule.

Comment: One commenter requested clarification of whether a provider that is being transitioned into the LTCH prospective payment system would be paid a percentage of ''the cost-based reimbursement rate'' or would the cost-based percentage be paid on an interim basis subject to cost report reconciliation.

Response: The cost-based percentage of a provider's total Medicare payment under the TEFRA payment system will be subject to cost report reconciliation.

We are revising the regulation text at § 412.533 to reflect this clarification.

In addition, it is now evident that the standard systems changes that are necessary to accommodate claims processing and payment under the new LTCH prospective payment system may not be in place by October 1, 2002. However, in order to comply with the statutory mandate to implement the LTCH prospective payment system no later than October 1, 2002, we are requiring that from October 1, 2002 until the systems changes are completed, all LTCHs, including those that elect to be paid based on 100 percent of the Federal rate, continue to submit their claims to and receive payment from their fiscal intermediaries as they otherwise would if the TEFRA payment system was still in effect. (We note that unless a LTCH that is required to comply with the HIPAA Administrative Simplification Standards obtains an extension in compliance with the Administrative Compliance Act, it must submit an electronic claim in compliance with 42 CFR 162.1002 and 42 CFR 1102 beginning October 16, 2002. Once the standard claims processing systems have been changed, the intermediary will ultimately reconcile any discrepancies between what LTCHs were paid and the payment amount determined under the LTCH prospective payment system. However, since the LTCH prospective payment system is in effect as of October 1, 2002, we would expect all bills submitted during this interim period to conform to the coding and billing guidelines as described in section VIII.H. of this preamble.

In proposed § 412.535, we proposed a schedule for publishing information on the LTCH prospective payment system for each fiscal year in the **Federal Register**, prior to the start of each fiscal year, on or before August 1. This cycle coincides with the statutorily mandated publication schedule for the inpatient acute care prospective payment system. Section 1886(e)(5) of the Act requires that for the acute care prospective payment system, the proposed rule be published in the **Federal Register** not later than ''the April 1 before each fiscal year''; and the final rule, not later than ''the August 1 before such fiscal year.'' The Act imposes no such requirement for the LTCH prospective payment system. Therefore, to avoid concurrent publications for these two systems, for purposes of administrative feasibility and efficiency, we will be considering a change in the schedule for updating the LTCH prospective payment system to be effective July 1 of each year. We will address this issue in the future.

O. Payments to New LTCHs

In the March 22, 2002 proposed rule, for the purposes of defining a new LTCH, we proposed under § 412.23(e)(4) to define a new LTCH as a provider of inpatient hospital services that (1) meets the revised qualifying classification criteria (described in section VIII.B. of this preamble and in § 412.23(e)(1)); and (2) under present or previous ownership (or both), has not received payment as a LTCH for discharges prior to October 1, 2002 (the effective date of the prospective payment system for LTCHs). We also proposed in § 412.500 that the LTCH prospective payment system applies to hospitals with a cost reporting period beginning on or after October 1, 2002.

We believe that these two statements are inconsistent because proposed § 412.23(e)(4) ties the status of a LTCH (that is, existing or new) to whether or not the hospital has received payment as a LTCH prior to the effective date of the LTCH prospective payment system, as opposed to focusing on whether the hospitals first cost reporting period begins on or after October 1, 2002 (the effective date of the statute). We believe the most appropriate focus in the instant case should be linked to the statute's emphasis of cost reporting periods beginning on or after October 1, 2002. In this final rule, we are revising the regulation so that the definition of a new LTCH more closely mirrors the statutory provision. Accordingly, for purposes of Medicare payment under the prospective payment system, we are defining a new LTCH as a provider of inpatient hospital services that otherwise meets the qualifying criteria for LTCHs, set forth in § 412.23(e)(1) and (e)(2) and, under present or previous ownership (or both), and its first cost reporting period as a LTCH begins on or after October 1, 2002. We are revising § 412.23(e)(4) to reflect this correction.

As noted above, new LTCHs will not participate in the 5-year transition from cost-based reimbursement to prospective payment (see section X.N. of this preamble). The transition period described in section X.N. of this preamble is intended to provide existing LTCHs time to adjust to payment under the new system. Since these new LTCHs with cost reporting periods beginning on or after October 1, 2002 would not have received payment under TEFRA for the delivery of LTCH services prior to the effective date of the LTCH prospective payment system, we do not believe that those new LTCHs require a transition period in order to make adjustments to their operations and capital financing, as will LTCHs that have been paid under TEFRA.

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

For example, a ''new'' LTCH (post-FY 1998) that first began receiving payment as a LTCH on October 1, 2001, will be subject to the 110 percent of the median target amount payment limit for LTCHs (in accordance with § 413.40(f)(2)(ii)) for both its FY 2002 (October 1, 2001 through September 30, 2002) and FY 2003 (October 1, 2002 through September 30, 2003) cost reporting periods. Assuming the hospital has not elected to be paid 100 percent of the Federal rate for its cost reporting period beginning on October 1, 2002 (the first cost reporting period when the LTCH will be subject to the prospective payment system), the hospital would be paid under the transition methodology whereby the LTCH's TEFRA portion of its payment for operating costs (80 percent) is limited by the 110 percent of the median target amount payment limit for LTCHs under § 413.40(f)(2)(ii). For its cost reporting period beginning on October 1, 2003 (which is the hospital's third cost reporting period), under the transition methodology, that LTCH's TEFRA portion of its payment for operating costs (60 percent) will be limited to its target amount as determined under § 413.40(c)(4)(v). Furthermore, if a hospital is designated as a LTCH on September 1, 2002, it would not be considered a new LTCH under § 412.23(e)(4), even if it had not discharged any patients or received any payments as of the implementation date of the LTCH prospective payment system on October 1, 2002, because its first cost reporting period didn't begin

on or after October 1, 2002. Thus, it would be paid according to § 413.40(f)(2)(ii) from September 1, 2002 through August 30, 2003. This LTCH would not be subject to payments under the LTCH prospective payment system until the start of its next cost reporting period on September 1, 2003. At the beginning of its second cost reporting period as a LTCH (that is, September 1, 2003), this LTCH would be subject to the transition period in § 412.533(a)(1), because this provision applies to cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003. Under the blended payments of the transition period in § 412.533(a)(1), 80 percent of payments for operating costs would be paid under the TEFRA system, as described in § 413.40(f)(2)(ii). (This hospital could also elect to be paid 100 percent of the Federal rate for its cost reporting period beginning September 1, 2003.) We did not receive any comments on this proposal.

P. Method of Payment

As discussed earlier, a Medicare patient will be classified into a LTC–DRG based on the principal diagnosis, up to eight additional (secondary) diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The LTC–DRG will be 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 since section 123(a) of Public Law 106–113 requires that the LTCH prospective payment system be a per discharge based system. The discharge bill provides data to allow for reclassifying the stay from payment at the full LTC–DRG rate to payment for a case as a short-stay outlier (under § 412.529) or as a interrupted stay (under § 412.531), or to determine if the case will qualify for a high-cost outlier payment (under § 412.525(a)).

Accordingly, the ICD–9–CM codes and other information used to determine if an adjustment to the full LTC–DRG payment is necessary (for example, length of stay or interrupted stay status) is recorded by the LTCH on the Medicare patient's discharge bill and submitted to the Medicare fiscal intermediary for processing. The payment made represents payment in full, under § 412.521(b), for inpatient operating and capital-related costs, but not the costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists or obtained under arrangement, or the costs of photocopying and mailing medical records requested by a QIO, which are costs paid outside the LTCH prospective payment system. We note that in this final rule, under § 412.521(b)(2)(i), we have added a reference to § 413.87 to indicate that payments for Medicare+Choice nursing and allied health education costs are made separate from payments under the LTCH prospective payment system.

Under the current payment system, a LTCH may elect to be paid using the periodic interim payment (PIP) method described in § 413.64(h), and may be eligible to receive accelerated payments as described in § 413.64(g). As we discussed in the proposed rule, with the implementation of a prospective payment system for LTCHs, we will continue to allow the PIPs method of payment as provided for under § 413.64(h) and accelerated payments as provided for under § 413.64(g) for qualified LTCHs.

We are adopting, as final, the proposed provisions for the methods of payment available to LTCHs. In addition, based on a commenter's concern, we wish to clarify a provision that for those LTCHs that choose not to elect to receive payments under the PIP method or that are not qualified to receive payment under the PIP method may continue to bill on an interim basis. Consistent with the interim payment provision under acute care hospital inpatient prospective payment system we are including a new subsection (d) at § 412.541 stating that LTCHs with unusually long lengths of stay, not receiving payment under the PIP method may bill on an interim basis. Consistent with the interim payment provisions under the acute care hospital inpatient prospective payment system at § 412.116(d), we believe that to allow those LTCHs experiencing unusually long stays to receive interim payments 60 days after an admission and every 60 days thereafter would help to alleviate any financial hardship that could result otherwise. We believe that this is both a fair and equitable solution. We are also including some technical changes to the language under § 413.64 to correct regulations citations to reflect the availability of the PIP method for LTCHs under the prospective payment systems.

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

Comment: Several commenters explained that LTCHs could experience financing difficulties because of the potentially lengthy period between the time a LTCH incurs costs to provide care and the date on which it receives payment following claims submission. One commenter stated that their provider bills on a cyclical basis, thus, allowing for more prompt receipt of payment from Medicare and more timely billing of deductibles and coinsurance to second insurers. Another commenter pointed out that some LTCHs do not qualify for the PIP method of payment. The commenter asked whether LTCHs that are currently receiving interim payments may switch to the PIP method. The commenter recommended that in order to avoid the heavy financial burden for LTCHs, these hospitals should be allowed to obtain interim payments similar to the method currently available to cost-based providers under the present regulations. In addition, some commenters expressed concern that Medicare fiscal intermediaries may not have the most current data upon which to base interim payments while others had questions regarding the timeliness and accuracy of the process used to determine PIP payments.

Response: As we stated above, we are revising the current regulations at § 412.541 to include a subsection (d) that allows LTCHs that are not receiving payments under the PIP method and that are experiencing unusually long stays to bill 60 days after an admission and every 60 days thereafter. Existing § 412.116(d) permits special interim payments for ''unusually long lengths of stay'' that it further describes as ''after a Medicare beneficiary has been in the hospital at least 60 days.'' LTCHs that

are presently receiving interim payments and would like to switch to the PIP method should contact their fiscal intermediary to determine whether they qualify under regulations at § 413.64(h) for such payments.

Since the comments regarding the accuracy of data and the timeliness of PIP determinations do not address issues that were specifically in the proposed rule, we are not responding to these comments in this final rule.

Comment: One commenter expressed concern with the definition of ''discharge bill'' under the proposed regulations. Specifically, the proposed regulation includes a definition recognizes a ''discharge'' when a patient exhausts Part A benefits during the inpatient stay. The commenter believes that this will create problems for business offices as most current billing systems are not designed to bill in the middle of a patient stay. This will necessitate additional spending on computer programming to properly submit bills.

Response: For LTCH prospective payment purposes, we have clarified the definition of discharge in § 412.503. For payment purposes, a Medicare patient in a LTCH is considered discharged when the patient has exhausted their Medicare Part A benefits (including lifetime reserve days) during a spell of illness (§ 413.40(a)). While we understand the commenter's concerns, our definition of ''discharge'' should not present new problems for LTCHs since under TEFRA, patients who have exhausted their Medicare Part A benefits are also considered to be discharged for Medicare payment purposes.

XI. Provisions of the Final Rule

We are establishing a new Subpart O under 42 CFR part 412, to implement the provisions of the prospective payment system for LTCHs as discussed in detail throughout the preamble to this final rule.

In addition, we are making additional policy changes and conforming changes to the following sections of the regulations under 42 CFR Parts 412, 413, and 476 as discussed throughout this preamble: §§ 412.1, 412.20, 412.22, 412.23, 412.116, 431.1, 413.40, 413.64, and 476.71.

XII. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this final rule as required by Executive Order 12866. We also have examined the impacts of this final rule under the criteria of the Regulatory Flexibility Act (RFA) (Public Law 96–354), section 1102(b) of the Social Security Act (the Act), the Unfunded Mandates Reform Act of 1995 (UMRA) (Public Law 104–4), and Executive Order 13132 (Federalism).

1. Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for final rules that constitute significant regulatory action, including rules that have an economic effect of $100 million or more in any one year (major rules). We have determined that this final rule would not be a major rule within the meaning of Executive Order 12866 because the redistributive effects do not constitute a shift of $100 million in any one year. Because the LTCH prospective payment system must be budget neutral in accordance with section 123(a)(1) of Public Law 106–113, we estimate that there will be no budgetary impact for the Medicare program. (Section XII.B.6. of this preamble includes an estimate of Medicare program payments for LTCH services.)

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses in issuing a final rule. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $25 million or less annually. For purposes of the RFA, all hospitals are considered small entities. Medicare fiscal intermediaries are not considered to be small entities. Individuals and States are not included in the definition of a small entity. Therefore, we certify that this final rule will not have a significant impact on a substantial number of small entities, in accordance with RFA.

3. Impact on Rural Hospitals

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. As discussed in detail in section XII.B. of this preamble, this final rule will not have a substantial impact on hospitals classified as located in rural areas that have fewer than 100 beds.

4. Unfunded Mandates

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

5. Federalism

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

We have examined this final rule under the criteria set forth in Executive Order 13132 and have determined that this final rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law.

B. Anticipated Effects

We discuss the impact of this final rule below in terms of its fiscal impact on the Federal Medicare budget and on LTCHs.

1. Budgetary Impact

Section 123(a)(1) of Public Law 106–113 requires us to set the payment rates contained in this final rule such that total payments under the LTCH prospective payment system are projected to equal the amount that would have been paid if this prospective payment system had not been implemented. However, the final unadjusted standard Federal rate ($34,956.15) was calculated as if all LTCHs will be paid based on 100 percent of the standard Federal rate in FY 2003. As discussed in section X.K.2.h. of this final rule, we are implementing a budget neutrality offset to payments (in addition to the budget neutrality adjustment reflected in the standard Federal rate) to account for the monetary effect of the 5-year transition period and the policy to permit LTCHs to elect to be paid based on 100 percent

of the standard Federal prospective payment rate rather than a blend of Federal prospective payments and reasonable cost-based payments during the transition. The amount of the offset is equal to 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would have been made if the LTCH prospective payment system had not been implemented, to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on 100 percent of the Federal prospective payment rate. Thus, in accordance with section 123(a)(1) Public Law 106–113, there will be no budgetary impact to the Medicare program by implementation of the LTCH prospective payment system. (Section XII.B.6. of this preamble includes an estimate of Medicare program payments for LTCH services.)

2. Impacts on Providers

In order to understand the impact of the new prospective payment system on different categories of LTCHs, it is necessary to estimate payments that will be made under the current (TEFRA) payment methodology (current payments) and payments under the prospective payment system (prospective payments). We also evaluated the ratio of estimated prospective payments to estimated costs for each category of LTCHs.

Hospital groups were based on characteristics provided in OSCAR data and 1999 cost report data from HCRIS. Hospitals with incomplete characteristics were grouped into the ''unknown'' category. Hospital groups include:

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

To estimate the impacts among the various categories of providers, it is imperative that current payments and prospective payments contain similar inputs. More specifically, we estimated prospective payments only for those providers that we are able to calculate current payment. For example, if we did not have FYs 1996 through 1999 cost data for a LTCH, we were unable to determine an update to the LTCH's target amount as described in section X.K. of this final rule to estimate payment under the TEFRA system.

As previously stated in section X.J. of this final rule, after excluding the data from those LTCHs that are all-inclusive rate providers or that are reimbursed in accordance with demonstration projects (section X.K.2.a. of this final rule), we have both case-mix and cost data for 198 LTCHs. Thus, those 198 providers were used in the regression analyses to determine the appropriateness of various adjustments to the final standard Federal payment rate. However, for the determination of the final unadjusted standard Federal rate ($34,956.15), we only had both Medicare claims data from the FY 2001 MedPAR file and cost data to estimate TEFRA payments for 194 providers. Thus, for the impact analyses shown in the following tables, we simulate payments for 194 LTCHs. The methodology used to update payment data to the midpoint of FY 2003 was based on the use of historical cost report data to determine the relationship between the LTCH's costs and the target amount. Thus, the number of providers reflects only those providers for which we had cost report data available from FYs 1996, 1997, 1998, and 1999 (see discussion in section X.K. of this final rule). We believe these hospitals provide sufficient data to determine appropriate LTC–DRG relative weights. Therefore, we believe the discharges of these 194 LTCHs are representative of the complete LTCH universe.

These impacts reflect the estimated losses or gains among the various classifications of providers for FY 2003. Prospective payments were based on the final standard Federal rate of $34,956.15 and the hospital's estimated case-mix based on FY 2001 claims data. These hospital payments were compared to the hospital's payments based on its cost from the cost report inflated to FY 2003 and subject to the updated per discharge target amount.

3. Calculation of Current Payments

To calculate current costs, cost report data are trended forward from the midpoint of the cost reporting period to the midpoint of FY 2003 using the methodology set forth in section X.K.2.b. of this final rule. To estimate current payments, we determined payments for operating costs for each LTCH in accordance with the methodology in section 1886(b) of the Act. In addition, for the purposes of these impact analyses, in estimating current payments, we took into consideration the increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs provided for by section 307(a)(1) of Public Law 106–554, and the enhanced bonus payments for LTCHs provided for by section 122 of Public Law 106–113. However, as we discuss in section X.K. of this final rule, in accordance with section 307(a)(2) of Public Law 106–554, the increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs provided for by section 307(a)(1) of Public Law 106–554, and the enhanced bonus payments for LTCHs provided for by section 122 of Public Law 106–113, were *not* taken into account in the development of the budget neutral standard Federal rate in the prospective payment system for LTCHs. Further, we compute payments for capital-related costs consistent with section 1886(g)(4) of the Act. To determine each LTCH's average per discharge payment amount under the current payment system, operating and capital-related payments are added together, and then the total payment is divided by the number of Medicare discharges from the cost reports. Total payments for each LTCH are then computed by multiplying the number of discharges from the FY 2001 MedPAR claims data by the average per discharge payment amount.

4. Calculation of Prospective Payments

To estimate payments under the LTCH prospective payment system, we simulated payments on a case-by-case basis by applying the final payment policy for short-stay outliers (as described in section X.C. of this final rule) and the adjustments for area wage differences (as described in section X.J.1. of this final rule) and for the cost-of-living for Alaska and Hawaii (as described in section X.J.5. of this final rule). Additional payments will also be made for high-cost outlier cases (as described in section X.J.6. of this final rule). As noted in section X.J. of this final rule, we will not make adjustments for geographic reclassification, indirect medical education costs, or a disproportionate share of low-income patients.

Next, we calculated payments using the transition blend percentages for FY 2003 (80 percent of current reasonable cost-based (TEFRA) payments and 20 percent of payments under the LTCH prospective payment system) and compared that estimated blended payment to the LTCH's estimated payment if it would elect payment based on 100 percent of the Federal rate (section X.N. of this final rule). If we estimated that a LTCH would be paid more based on 100 percent of the Federal rate, we assumed that it would elect to bypass the transition methodology and transition immediately to prospective payments.

Then we applied the 6.6 percent reduction to payment to account for the effect of the 5-year transition methodology and election of payment

based on 100 percent of the Federal rate on Medicare program payments to each LTCH's estimated payments under the prospective payment system (section X.K.2.h. of this final rule). The impact based on our projection of whether a LTCH will be paid based on the transition blend methodology or will elect payment based on 100 percent of the Federal rate for cost reporting periods beginning during FY 2003 is shown below in Table I.

In Table II below, we also show the impact if the LTCH prospective payment system were fully implemented in FY 2003; that is, as if there were an immediate transition to fully Federal prospective payments under the LTCH prospective payment system for FY 2003. Accordingly, the 6.6 percent reduction to account for the 5-year transition methodology on LTCHs' Medicare program payments was not applied to LTCHs' estimated payments under the prospective payment system. Furthermore, starting with cost reporting periods that begin during FY 2007, the 5-year transition period would have ended, and all LTCHs would be paid based on 100 percent of the standard Federal rate. All payment simulations reflect data trended to the midpoint FY 2003.

Tables I and II below illustrate the aggregate impact of the payment system among various classifications of LTCHs. The first column, LTCH Classification, identifies the type of LTCH. The second column lists the number of LTCHs of each classification type; the third column identifies the number of long-term care cases; and the fourth column shows the ratio of prospective payments to current payments.

As we discuss in section X.K. of this final rule, in accordance with section 307(a)(2) of Public Law 106–554, the increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs provided for by section 307(a)(1) of Public Law 106–554, and the enhanced bonus payments for LTCHs provided for by section 122 of Public Law 106–113, were *not* taken into account in the development of the budget neutral standard Federal rate in the prospective payment system for LTCHs. However, as we noted above, for the purposes of these impact analyses, in estimating current payments under the TEFRA payment system, we took into consideration the increases to the hospital-specific target amounts and cap on the target amounts for LTCHs provided for by section 307(a)(1) of Public Law 106–554, and the enhanced bonus payments for LTCHs provided for by section 122 of Public Law 106–113. Including these provisions in our estimate of current payments to LTCHs under the TEFRA payment system increases payments to LTCHs' under the TEFRA payment system in the aggregate by approximately 3 percent. Since payments made to LTCHs under the LTCH prospective payment system must be budget neutral to payments made to LTCHs under the TEFRA payment system *without* the increases provided for by those provisions, the ''New Payment to Current Payment Ratio'' for all providers shown in Tables I and II below equals approximately 0.97 instead of 1.00.

TABLE I.—PROJECTED IMPACT REFLECTING 20 PERCENT OF PROSPECTIVE PAYMENTS AND 80 PERCENT OF CURRENT (TEFRA) PAYMENTS AND OPTION TO ELECT PAYMENT BASED ON 100 PERCENT OF THE FEDERAL RATE

LTCH classification	Number of LTCHs	Number of LTCH cases	New payment to current payment ratio
All Providers	194	72,149	0.9762
By Location:			
Rural	6	2,189	1.0539
Urban	188	69,960	0.9754
Large	121	50,296	0.9814
Other	67	19,664	0.9569
By participation date:			
After October 1993	125	42,617	0.9632
Before October 1983	17	7,841	1.0200
October 1983–September 1993	48	20,795	0.9908
Unknown	4	896	1.0261
By ownership control:			
Voluntary	49	19,073	0.9634
Proprietary	134	50,616	0.9769
Government	11	2,460	1.0633
By census region:			
New England	14	9,487	1.0289
Middle Atlantic	9	3,276	1.0405
South Atlantic	18	6,265	1.0067
East North Central	33	9,245	0.9994
East South Central	11	3,314	0.9860
West North Central	11	2,898	1.0006
West South Central	71	30,248	0.9415
Mountain	15	2,491	0.9647
Pacific	12	4,925	0.9729
By bed size:			
Beds: 0–24	20	3,119	0.9926
Beds: 25–49	81	20,659	0.9756
Beds: 50–74	19	7,433	0.9593
Beds: 75–124	27	13,248	0.9768
Beds: 125–199	23	13,035	0.9739
Beds: 200 +	24	14,655	0.9839

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

LTCH classification	Number of LTCHs	Number of LTCH cases	New payment to current payment ratio
All Providers	194	72,149	0.9767
By Location:			
Rural	6	2,189	1.0963
Urban	188	69,960	0.9740
Large	121	50,296	0.9833
Other	67	19,664	0.9505
By participation date:			
After October 1993	125	42,617	0.9566
Before October 1983	17	7,841	1.0560
October 1983–September 1993	48	20,795	0.9955
Unknown	4	896	0.9502
By ownership control:			
Voluntary	49	19,073	0.9641
Proprietary	134	50,616	0.9780
Government	11	2,460	1.0447
By census region:			
New England	14	9,487	1.0676
Middle Atlantic	9	3,276	1.0918
South Atlantic	18	6,265	1.0018
East North Central	33	9,245	1.0212
East South Central	11	3,314	1.0175
West North Central	11	2,898	1.0187
West South Central	71	30,248	0.9213
Mountain	15	2,491	0.9323
Pacific	12	4,925	0.9676
By bed size:			
Beds: 0–24	20	3,119	0.9827
Beds: 25–49	81	20,659	0.9838
Beds: 50–74	19	7,433	0.9125
Beds: 75–124	27	13,248	0.9687
Beds: 125–199	23	13,035	0.9955
Beds: 200 +	24	14,655	0.9909

5. Results

We have prepared the following summary of the impact (as shown in Table I) of the LTCH prospective payment system set forth in this final rule.

a. Location

The majority of LTCHs are in urban areas. Approximately 3 percent of the LTCHs are identified as being located in a rural area, and approximately 3 percent of all LTCH cases are treated in these rural hospitals. Impact analysis in Table I shows that the new payment to current payment ratio is estimated to be 1.0539 for rural LTCHs, and 0.9754 for urban LTCHs. About 70 percent of the LTCH cases are in LTCHs located in large urban areas. Large urban LTCHs have a new payment to current payment ratio of 0.9814, while other urban LTCHs have a new payment to current payment ratio of 0.9569. (Table I)

b. Participation Date

LTCHs are grouped by participation date into three categories: (1) Before October 1983; (2) between October 1983 and September 1993; and (3) after October 1993. We did not have sufficient OSCAR data on four LTCHs, which we labeled as an ''Unknown'' category. The majority, approximately 59 percent, of the LTCH cases are in hospitals that began participating after October 1993 and have a new payment to current payment ratio of 0.9632 and approximately 11 percent of the cases are in LTCHs that began participating in Medicare before October 1983 with a new payment to current payment ratio of 1.0200. (Table I)

c. Ownership Control

LTCHs are grouped into three categories based on ownership control type: (1) Voluntary; (2) proprietary; and (3) government. We expect that government LTCHs will gain the most from the payment system with an estimated new payment to current payment ratio of 1.0633, although only approximately 6 percent of LTCHs are government run. Voluntary and proprietary LTCHs have a new payment to current payment ratio of 0.9634 and 0.9769, respectively. (Table I)

d. Census Region

LTCHs located in most regions are expected to have a new payment to current payment ratio of greater than 0.97 percent. Of the nine census regions, we expect that LTCHs in the Middle Atlantic Region will have the highest new payment to current payment ratio (1.0405). We expect only LTCHs in the West South Central and Mountain Regions will have a new payment to current payment ratio of less than 0.97 percent (0.9415 and 0.9647, respectively). (Table I)

e. Bed Size

LTCHs were grouped into six categories based on bed size: 0–24 beds, 25–49 beds, 50–74 beds, 75–124 beds, 125–199 beds, and 200+ beds. The new payment to current payment ratios for all bed size categories is expected to be greater than 0.95 percent. The majority of LTCHs were in bed size categories where the new payment to current payment ratio is estimated to be greater than 0.97 percent. LTCHs with between 0–24 beds have the highest estimated new payment to current payment ratio (0.9926), while LTCHs with between 50–74 beds have the lowest estimated new payment to current payment ratio (0.9593). (Table I)

6. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other prospective payment systems, we estimate that Medicare spending (total Medicare program payments) for LTCH services over the next 5 years would be:

Fiscal year	Estimated payments ($ in millions)
2003	$1,590
2004	1,690
2005	1,790
2006	1,900
2007	2,000

These estimates are based on the current estimate of increase in the excluded hospital market basket of 3.5 percent for FY 2003, 3.4 percent for FY 2004, 3.5 percent for FY 2005, 3.2 percent for FY 2006, and 2.9 percent for FY 2007. We estimate that there would be an increase in Medicare beneficiary enrollment of 1.7 percent in FY 2003, 1.8 percent in FY 2004, 1.5 percent in FYs 2005 and 2006, and 1.9 percent in FY 2007, and an estimated increase in the total number of LTCHs.

Consistent with the statutory requirement for budget neutrality, we intend for estimated aggregate payments under the LTCH prospective payment system to equal the estimated aggregate payments that would be made if the LTCH prospective payment system were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the best available data and necessarily reflects assumptions. When the LTCH prospective payment system is implemented, we will monitor payment data and evaluate the ultimate accuracy of the assumptions used to calculate the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH prospective payment system, as discussed in section X.K. of this final rule). To the extent the assumptions significantly differ from actual experience, the aggregate amount of actual payments may turn out to be significantly higher or lower than the estimates on which the budget neutrality calculations are based.

Section 123 of Public Law 106–113 and section 307 of Public Law 106–554 provide the Secretary extremely broad authority in developing the LTCH prospective payment system, including the authority for appropriate adjustments. In accordance with this broad authority, we plan to discuss in a future proposed rule a possible one-time prospective adjustment to the LTCH prospective payment system rates so that the effect of the difference between actual payments and estimated payments for the first year of LTCH prospective payment system is not perpetuated in the prospective payment system rates for future years. (We note that in other contexts (for example, outlier payments under the acute care hospital inpatient prospective payment system) differences between estimated payments and actual payments for a given year are not built into the prospective payment system rates for subsequent years. However, the statutory ratesetting scheme under the LTCH prospective payment system is very different than in other contexts.)

7. Effect on Medicare Beneficiaries

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

8. Computer Hardware and Software

We do not anticipate that hospitals will incur additional systems operating costs in order to effectively participate in the prospective payment system for LTCHs. We believe that LTCHs possess the computer hardware capability to handle the LTC–DRGs, computerization, data transmission, and GROUPER software requirements. Our belief is based upon indications that approximately 99 percent of hospital inpatient claims currently are submitted electronically. Moreover, LTCHs have the option of purchasing data collection software that can be used to support other clinical or operational needs (for example, care planning, quality assurance, or billing) or other regulatory requirements for reporting patient information.

C. Alternatives Considered

Section 123 of Public Law 106–113 specifies that the case-mix adjusted prospective payment system must be a per discharge system based on DRGs, and section 307(b) of Public Law 106–554 directs the Secretary to examine the ''feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnosis-related groups (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.'' Section 307(b) further requires the Secretary to ''examine'' appropriate adjustments to the system such as adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment consistent with section 1886(d)(5)(F) of the Act. Generally, the statute confers broad authority on the Secretary in designing the key elements of the system. Our considerations of the patient classification systems are explained in detail in section IX.G. of this final rule. Our evaluation of alternative features and adjustment factors for the LTCH prospective payment system are set forth in section X.J. of this final rule. In the March 22, 2002 proposed rule, we solicited public comments regarding our proposed policies and system design. Those public comments and our responses are located in the appropriate subject sections.

D. Executive Order 12866

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

XIII. Collection of Information Requirements

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

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

In the March 22, 2002 proposed rule, we solicited and received no public comments on each of these issues for the following proposed sections that contain information collection requirements:

§§ 412.116(a)(4) and 412.541(b) and (e) Method of payment: periodic interim payments and accelerated payments.

Under § 412.116(a)(4), for cost reporting periods beginning on or after October 1, 2002, payments to a LTCH for inpatient hospital services under the prospective payment system would be made as described in § 412.541. Section 412.541(b) provides that a LTCH may receive periodic interim payments for Part A services, subject to the provisions of § 413.64(h). Section 413.64(h) specifies that the request for periodic interim payments must be made to the fiscal intermediary. Section 412.541(e) states that, upon request, an accelerated payment may be made to a LTCH that is not receiving a periodic interim payment if the LTCH is experiencing financial difficulties.

We estimate that the burden associated with this provision is the time it takes a LTCH to prepare and submit its request for periodic interim payments or accelerated payments. We estimate that approximately three LTCHs would request periodic interim payments under the prospective payment system and that it would take each hospital 1 hour to prepare and make the request. We estimate that approximately two LTCHs would request accelerated payments and that it would take them approximately 30 minutes each to prepare and submit their written request, for a total estimated annual burden of 1 hour.

Both of these sections of the regulations are exempt from the PRA since the two requirements would affect less than 10 LTCHs per year (see 5 CFR Part 1320.3(c)(4)).

§ 412.508(b)(1) and (b)(2) Content of physician acknowledgement statement and completion of acknowledgement.

Section 412.508(b) provides that a physician must complete an acknowledgement statement that each patient's principal and secondary diagnoses and major procedures performed are documented by the physician's entries in the patient's medical record. Section 412.508(b)(1) specifies that when a claim is submitted, the LTCH must have a signed and dated acknowledgement from the attending physician that the physician has received notice of the required acknowledgement of entries in the patient's medical record and that anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable laws. Section 412.508(b)(2) specifies that the acknowledgement must be completed by the physician at the time the physician is granted admitting privileges at the hospital or before or at the time the physician admits his or her first patient. In addition, under this section, there is a requirement for LTCHs to enter into an agreement with a QIO.

As stipulated under section 4202(b) ''Waiver of Paperwork Reduction,'' of Public Law 100–203, these collection requirements are exempt from the PRA.

§ 412.511 Reporting and recordkeeping requirements.

Under § 412.511, a LTCH subject to the prospective payment system described in this final rule must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24. While §§ 413.20 and 413.24 are subject to the PRA, the burden associated with these requirements are currently captured in approved collections 0938–0463, expiration date of May 31, 2004; 0938–0758, expiration date of February 28, 2005; 0938–0037, expiration date of February 28, 2005; and 0938–0050 expiration date of May 31, 2004.

§ 412.533(b) Transition payments: Election not to be paid under the transitional period methodology.

Under § 412.533(b), a LTCH may elect to be paid based on 100 percent of the Federal prospective payment rate at the start of any of its cost reporting periods during a 5-year transition period beginning on or after October 1, 2002, and before October 1, 2007, without regard to the transitional percentages. Section 412.533(b) specifies that the request to make the election must be made in writing to the Medicare intermediary by the LTCH and received no later than November 1, 2002 for cost reporting periods beginning on or after October 1, 2002 through November 30, 2002 and no later than 30 days before the beginning of the cost reporting period for cost reporting periods beginning on or after December 1, 2002.

We estimate that 94 LTCHs would make a request to elect to receive the full Federal prospective payment rate and that it would take each LTCH approximately 15 minutes each to prepare and submit their written request, for a total estimated annual burden of 24 hours.

Based on comments received and our analysis of planned monitoring activities, in this final rule we have added an additional requirement regarding collection of information at § 412.22 concerning a LTCH's (or a LTCH satellite's) notification to its Medicare fiscal intermediary and CMS of its co-located status. Under §§ 412.22(e)(6) and (h)(5), a LTCH or a satellite of a LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

We estimate that the burden associated with this provision is the time it would take for a LTCH or a satellite of a LTCH to prepare and submit its notification to its fiscal intermediary and CMS. At this time, we estimate that 100 LTCHs and satellites of LTCHs will take 15 minutes each to comply with these provisions for a total burden of 25 hours. The total burden associated with the collection requirements referenced in this rule is 49 annual hours.

We have submitted the information collection requirements under §§ 412.22 and 412.533 to the Office of Management and Budget (OMB) for review under the authority of PRA. These requirements are not effective until they are approved by OMB.

If you have any comments on the information collection requirements of §§ 412.22(e)(6) and (h)(5), please mail one original and three copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Standards and Security Group, Office of Regulations Development and Issuances, 7500 Security Boulevard, Room N2–14–26, Baltimore, MD 21244–1850, Attn: John Burke, CMS–1177–F; and

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

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 476

Health care, Health professional, Health record, Peer Review Organizations (PRO), Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Chapter IV is amended 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).

Subpart A—General Provisions

2. Section § 412.1 is amended by:

a. Adding a new paragraph (a)(3);

b. Redesignating paragraph (b)(12) as paragraph (b)(13); and

c. Adding a new paragraph (b)(12).

§ 412.1 Scope of part.

(a) *Purpose.* * * *

(3) This part implements section 123 of Public Law 106–113, which provides for the establishment of a prospective payment system for the costs of inpatient hospital services furnished to Medicare beneficiaries by long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act, for cost reporting periods beginning on or after October 1, 2002. This part also reflects the provisions of section 307 of Public Law 106–554, which state that the Secretary shall examine and may provide for appropriate adjustments to the long-term care hospital prospective payment system, including adjustments to diagnosis-related group (DRG) weights, area wage adjustments, geographic reclassification, outlier adjustments, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(b) *Summary of content.* * * *

(12) Subpart O of this part describes the prospective payment system specified in paragraph (a)(3) of this section for long-term care hospitals and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals, effective with cost reporting periods beginning on or after October 1, 2002.

* * * * *

Subpart B—Hospital Services Subject to and Excluded from the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

a. Revising paragraph (a).

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

c. Adding a new paragraph (c).

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b), (c), and (d) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in § 412.1(a)(1).

* * * * *

(c) Effective for cost reporting periods beginning on or after October 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a long-term care hospital that meets the conditions for payment of §§ 412.505 through 412.511 are paid under the prospective payment system described in subpart O of this part.

* * * * *

4. Section 412.22 is amended by revising paragraph (b) and adding a new paragraph (e)(6) and (h)(5) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section and §§ 412.20(b) and (c), all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this subchapter.

* * * * *

(e) *Hospitals-within-hospitals.* * * *

(6) *Notification of co-located status.* A long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (e)(1) through (e)(5) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

* * * * *

(h) *Satellite facilities.* * * *

(5) *Notification of co-located status.* A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period beginning on or after October 1, 2002.

5. Section 412.23 is amended by revising paragraph (e) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) *Long-term care hospitals.* A long-term care hospital must meet the requirements of paragraph (e)(1) and (e)(2) of this section and, where applicable, the additional requirements of § 412.22(e), to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(3) and in Subpart O of this part.

(1) *Provider agreements.* The hospital must have a provider agreement under Part 489 of this chapter to participate as a hospital; and

(2) *Average length of stay.* (i) The hospital must have an average Medicare inpatient length of stay of greater than 25 days (which includes all covered and noncovered days of stay of Medicare patients) as calculated under paragraph (e)(3) of this section; or

(ii) For cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the prospective payment system under this section in 1986 meets the length of stay criterion if it has an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and demonstrates that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

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

(ii) If a change in the hospital's Medicare average length of stay is indicated, the calculation is made by the same method for the immediately preceding 6-month period.

(iii) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the preceding 6 months, the hospital may be excluded from the prospective payment system as a long-

term care hospital for a cost reporting period if, for the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required Medicare average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

(4) *Definition of new long-term care hospital.* For purposes of payment under the long-term care hospital prospective payment system under Subpart O of this part, a new long-term care hospital is a provider of inpatient hospital services that meets the qualifying criteria in paragraphs (e)(1) and (e)(2) of this section and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002.

* * * * *

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

6. In § 412.116, the heading of paragraph (a) is revised and a new paragraph (a)(4) is added to read as follows:

§ 412.116 Method of payment.

(a) *General rules.* * * *

(4) For cost reporting periods beginning on or after October 1, 2002, payments for inpatient hospital services furnished by a long-term care hospital that meets the conditions for payment of §§ 412.505 through 412.511 are made as described in § 412.521.

* * * * *

7. A new subpart O is added to read as follows:

Subpart O—Prospective Payment System for Long-Term Care Hospitals

Sec.

Subpart O—Prospective Payment System for Long-Term Care Hospitals

§ 412.500 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 123 of Public Law 106–113, which provides for the implementation of a prospective payment system for long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act. This subpart also reflects the provisions of section 307 of Public Law 106–554, which state that the Secretary shall examine and may provide for appropriate adjustments to that system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for long-term care hospitals, including the methodology used for the development of payment rates and associated adjustments and related rules. Under this system, for cost reporting periods beginning on or after October 1, 2002, payment for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals is made on the basis of prospectively determined rates and applied on a per discharge basis.

§ 412.503 Definitions.

As used in this subpart—

CMS stands for the Centers for Medicare & Medicaid Services.

Discharge. A Medicare patient in a long-term care hospital is considered discharged when—

(1) For purposes of the long-term care hospital qualification calculation, as described in § 412.23(e)(3), the patient is formally released;

(2) For purposes of payment, as described in § 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

(3) The patient dies in the long-term care facility.

LTC–DRG stands for the diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

QIO (formerly PRO or Peer Review Organization) stands for the Quality Improvement Organization.

§ 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

(a) *Long-term care hospitals subject to the prospective payment system.* To be eligible to receive payment under the prospective payment system specified in this subpart, a long-term care hospital must meet the criteria to be classified as a long-term care hospital set forth in § 412.23(e) for exclusion from the acute care hospital inpatient prospective payment systems specified in § 412.1(a)(1). This condition is subject to the special payment provisions of § 412.22(c), the provisions on change in hospital status of § 412.22(d), the provisions related to hospitals-within-hospitals under § 412.22(e), and the provisions related to satellite facilities under § 412.22(h).

(b) *General requirements.* (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(6) and (h)(5), and §§ 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a long-term care hospital fails to comply fully with these conditions for payment with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may withhold (in full or in part) or reduce Medicare payment to the hospital.

§ 412.507 Limitation on charges to beneficiaries.

(a) *Prohibited charges.* Except as provided in paragraph (b) of this section, a long-term care hospital may not charge a beneficiary for any covered services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system. If Medicare has paid the full LTC–DRG payment, that payment applies to the hospital's costs for services furnished until the high-cost outlier threshold is met. If Medicare pays less than the full LTC–DRG payment, that payment only applies to the hospital's costs for those costs or

days used to calculate the Medicare payment.

(b) *Permitted charges.* (1) A long-term care hospital that receives a full LTC–DRG payment under this subpart for covered days in a hospital stay may charge the Medicare beneficiary only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter, and for items and services as specified under § 489.20(a) of this chapter.

(2) A long-term care hospital that receives less than the full LTC–DRG payment for a short-stay case, in accordance with § 412.529, may only charge the Medicare beneficiary for the applicable deductible and coinsurance under §§ 409.82, 409.83, and 409.87 of this subchapter, for items and services as specified under § 489.20(a) of this chapter, and for services provided during the stay that were not the basis for the short-stay payment.

§ 412.508 Medical review requirements.

(a) *Admission and quality review.* A long-term care hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(1) The medical necessity, reasonableness, and appropriateness of hospital admissions and discharges.

(2) The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.523(d)(1) and 412.525(a).

(3) The validity of the hospital's diagnostic and procedural information.

(4) The completeness, adequacy, and quality of the services furnished in the hospital.

(5) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

(b) *Physician acknowledgement.* Payment under the long-term care hospital prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record. The hospital must assure that physicians complete an acknowledgement statement to this effect in accordance with paragraphs (b)(1) and (b)(2) of this section.

(1) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(2) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(c) *Denial of payment as a result of admissions and quality review.*

(1) If CMS determines, on the basis of information supplied by a QIO, that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission or unnecessary multiple admissions of an individual entitled to benefits under Part A, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may, as appropriate—

(i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or

(ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (c)(1) of this section, and liability is not waived in accordance with §§ 411.400 through 411.402 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(3) A determination under paragraph (c)(1) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system, is referred to the Department's Office of Inspector General for handling in accordance with § 1001.301 of this title.

§ 412.509 Furnishing of inpatient hospital services directly or under arrangement.

(a) Subject to the provisions of § 412.521(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following:

(1) Physicians' services that meet the requirements of § 415.102(a) of this subchapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this subchapter.

(b) Medicare does not pay any provider or supplier other than the long-term care hospital for services furnished to a Medicare beneficiary who is an inpatient of the hospital except for services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The long-term care hospital must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements (as defined in § 409.3 of this subchapter).

§ 412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§ 412.22(e)(6), 412.22(h)(5), 413.20, and 413.24 of this subchapter.

§ 412.513 Patient classification system.

(a) *Classification methodology.* CMS classifies specific inpatient hospital discharges from long-term care hospitals by long-term care diagnosis-related groups (LTC–DRGs) to ensure that each hospital discharge is appropriately assigned based on essential data abstracted from the inpatient bill for that discharge.

(b) *Assignment of discharges to LTC–DRGs.*

(1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and the patient's discharge status.

(2) Each discharge from a long-term care hospital is assigned to only one LTC-DRG (related, except as provided in paragraph (b)(3) of this section, to the

patient's principal diagnosis), regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. The LTC–DRG classification system provides a LTC–DRG, and an appropriate weighting factor, for those cases for which none of the surgical procedures performed are related to the principal diagnosis.

(c) *Review of LTC–DRG assignment.*

(1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a LTC–DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews that hospital's request and any additional information and decides whether a change in the LTC–DRG assignment is appropriate. If the intermediary decides that a different LTC–DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 476.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (c)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

§ 412.515 LTC–DRG weighting factors.

For each LTC–DRG, CMS assigns an appropriate weight that reflects the estimated relative cost of hospital resources used within that group compared to discharges classified within other groups.

§ 412.517 Revision of LTC-DRG group classifications and weighting factors.

CMS adjusts the classifications and weighting factors annually to reflect changes in—

(a) Treatment patterns;

(b) Technology;

(c) Number of discharges; and

(d) Other factors affecting the relative use of hospital resources.

§ 412.521 Basis of payment.

(a) *Method of payment.*

(1) Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate established in accordance with § 412.523, including adjustments described in § 412.525, and, if applicable during a transition period, on a blend of the Federal payment rate and the cost-based reimbursement rate described in § 412.533.

(b) *Payment in full.*

(1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance described in subpart G of part 409 of this subchapter) for covered inpatient operating costs as described in § 412.2(c) and capital-related costs described in subpart G of part 413 of this subchapter associated with furnishing Medicare covered services in long-term care hospitals.

(2) In addition to payment based on prospective payment rates, long-term care hospitals may receive payments separate from payments under the prospective payment system for the following:

(i) The costs of approved medical education programs described in §§ 413.85, 413.86, and 413.87 of this subchapter.

(ii) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this subchapter.

(iii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(iv) Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements, as specified in § 412.113(c)(2).

(v) The costs of photocopying and mailing medical records requested by a QIO, in accordance with § 476.78(c) of this chapter.

(c) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan that is primary to Medicare pays in full or in part, payment is determined in accordance with the guidelines specified in § 412.120(b).

(d) *Effect of change of ownership on payments under the prospective payment system.* When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(1) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments as provided in § 412.525 and payments for hemophilia clotting factor costs as provided in paragraph (b)(2)(iii) of this section, are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Other payments for the direct costs of approved medical education programs, bad debts, anesthesia services furnished by hospital employed nonphysician anesthetists, and costs of photocopying and mailing medical records to the QIO as provided for under paragraphs (b)(2)(i), (ii), (iv), and (v) of this section are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

§ 412.523 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the initial prospective payment rates for inpatient hospital services furnished by long-term care hospitals, CMS uses—

(1) The best Medicare data available; and

(2) A rate of increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient long-term care hospital services.

(b) *Determining the average costs per discharge for FY 2003.* CMS determines the average inpatient operating and capital-related costs per discharge for which payment is made to each inpatient long-term care hospital using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to FY 2003 by a rate of increase factor, described in paragraph (a)(2) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(c) *Determining the Federal prospective payment rates.*

(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard Federal rate. The standard Federal rate is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor

described in paragraph (a)(2) of this section to each hospital's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for FY 2003. Based on the updated cost per discharge, CMS estimates the payments that would have been made to each hospital for FY 2003 under Part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

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

(i) *For FY 2003.* Based on the updated costs per discharge and estimated payments for FY 2003 determined in paragraph (c)(2) of this section, CMS computes a standard Federal rate for FY 2003 that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after FY 2003.* The standard Federal rate for fiscal years after FY 2003 will be the standard Federal rate for the previous fiscal year, updated by the increase factor described in paragraph (a)(2) of this section, and adjusted as appropriate as described in paragraph (d) of this section.

(4) *Determining the Federal prospective payment rate for each LTC–DRG.* The Federal prospective payment rate for each LTC–DRG is the product of the weighting factors described in § 412.515 and the standard Federal rate described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard Federal rate.* The standard Federal rate described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in § 412.525(a).

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been paid to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart, excluding the effects of sections 1886(b)(2) and (b)(3) of the Act.

(3) The Secretary will review payments under this prospective payment system and may make a one-time prospective adjustment to the LTCH prospective payment system rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH prospective payment system is not perpetuated in the prospective payment rates for future years.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, a long-term care hospital's Federal prospective payment is computed on the basis of the Federal prospective payment rate multiplied by the relative weight of the LTC–DRG assigned for that discharge. A hospital's Federal prospective payment rate will be adjusted, as appropriate, to account for outliers and other factors as specified in § 412.525.

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.* CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC–DRG payment plus a fixed-loss amount. For each fiscal year, CMS determines a fix-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs. The additional payment equals 80 percent of the difference between the estimated cost of the patient case (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the adjusted Federal prospective payment for the LTC–DRG prospective payment system payment and the fixed-loss amount. No retroactive adjustments will be made to the outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge-ratios and the actual cost-to-charge-ratios of the case.

(b) *Adjustments for Alaska and Hawaii.* CMS adjusts the Federal prospective payment for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(c) *Adjustments for area levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively.

(d) *Special payment provisions.* CMS adjusts the Federal prospective payment to account for—

(1) Short-stay outliers, as provided for in § 412.529; and

(2) Interruption of a stay, as provided for in § 412.531.

§ 412.529 Special payment provision for short-stay outliers.

(a) *Short-stay outlier defined.* ''Short-stay outlier'' means a discharge with a length of stay in a long-term care hospital that is up to and including five-sixths of the geometric average length of stay for each LTC–DRG.

(b) *Adjustment to payment.* CMS adjusts the hospital's Federal prospective payment to account for any case that is determined to be a short-stay outlier, as defined in paragraph (a) of this section, under the methodology specified in paragraph (c) of this section.

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

(1) The adjusted payment amount for a short-stay outlier is the least of the following amounts:

(i) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (c)(2) of this section multiplied by the length of stay of the discharge;

(ii) 120 percent of the cost of the case determined under paragraph (c)(3) of this section; or

(iii) The Federal prospective payment for the LTC–DRG.

(2) CMS calculates a per diem amount for short-stay outliers for each LTC–DRG by dividing the product of the standard Federal payment rate and the LTC–DRG weight by the geometric mean length of stay of the specific LTC–DRG.

(3) To determine the cost of a case, CMS uses the hospital-specific cost-to-charge ratio and the Medicare allowable charges for the case.

(4) CMS will not make any retroactive adjustments to the payments for short-stay outliers to account for changes made to the LTCH's hospital-specific cost-to-charge ratio.

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

(a) *Interruption of a stay defined.* ''Interruption of a stay'' means a stay at a long-term care hospital during which a Medicare inpatient is transferred upon discharge to an acute care hospital, an IRF, or a SNF for treatment or services that are not available in the long-term care hospital and returns to the same long-term care hospital within the applicable fixed day period specified in paragraphs (a)(1) through (a)(3) of this section.

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

(2) For a discharge to an IRF, the applicable fixed day period is 27 days.

The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 27th day after the discharge.

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

(b) *Methods of determining payments.*

(1) For purposes of determining a Federal prospective payment, any stay in a long-term care hospital that involves an interruption of the stay will be paid as a single discharge from the long-term care hospital. The number of days that a beneficiary spends in an acute care hospital, an IRF, or a SNF during an interruption of stay at a long-term care hospital is not included in determining the length of stay of the patient at the long-term care hospital. CMS will make only one LTC–DRG payment for all portions of a long-term care stay that involves an interruption of a stay. In accordance with § 412.513(b), payment will be based on the patient's LTC–DRG that would be determined by the principal diagnosis, which is the condition established after study to be chiefly responsible for occasioning the first admission of the patient to the hospital for care.

(2) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following an interruption of a stay is up to and including five-sixths of the geometric average length of stay of the LTC–DRG, CMS will make a Federal prospective payment for a short-stay outlier in accordance with § 412.529(c).

(3) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following an interruption of a stay exceeds five-sixths of the geometric average length of stay for the LTC–DRG, CMS will make one full Federal LTC–DRG prospective payment for the case. An additional payment will be made if the patient's stay qualifies as a high-cost outlier, as set forth in § 412.525(a).

(4) Notwithstanding the provisions of paragraph (a) of this section, if a patient who has been discharged from a long-term care hospital to another facility and is readmitted to the long-term care hospital for additional treatment or services in the long-term care hospital following the stay at the other facility, the subsequent admission to the long-term care hospital is considered a new stay, even if the case is determined to fall into the same LTC–DRG, and the long-term care hospital will receive two separate Federal prospective payments if one of the following conditions are met:

(i) The patient has a length of stay in the acute care hospital that exceeds 9 days from the day of discharge from the long-term care hospital;

(ii) The patient has a length of stay in the IRF that exceeds 27 days from the day of discharge from the long-term care hospital; or

(iii) The patient has a length of stay in the SNF that exceeds 45 days from the day of discharge from the long-term care hospital.

(c) *Payments to an acute care hospital, an IRF, or a SNF during an interruption of a stay.*

(1) Payment to the acute care hospital for the acute care hospital stay following discharge from the long-term care hospital will be paid in accordance with the acute care hospital inpatient prospective payment systems specified in § 412.1(a)(1).

(2) Payment to an IRF for the IRF stay following a discharge from the long-term care hospital will be paid in accordance with the IRF prospective payment system specified in § 412.624 of Subpart P of this part.

(3) Payment to a SNF for the SNF stay following a discharge from the long-term care hospital will be paid in accordance with the SNF prospective payment system specified in subpart J of Part 413 of this subchapter.

§ 412.532 Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.

(a) The policies set forth in this section apply in the following situations:

(1) A long-term care hospital (including a satellite facility) that is co-located within an onsite acute care hospital, an onsite IRF, or an onsite psychiatric facility or unit that meets the definition of a hospital-within-a-hospital under § 412.22(e).

(2) A satellite facility, as defined in § 412.22(f), that is co-located with the long-term care hospital.

(3) A SNF, as defined in section 1819(a) of the Act, that is co-located with the long-term care hospital.

(b) As used in this section, ''co-located'' or ''onsite'' facility means a hospital or unit that occupies space in a building also used by another hospital or unit or in one or more buildings on the same campus, as defined in § 413.65(a)(2) of this subchapter, as buildings used by another hospital or unit.

(c) If, during a cost reporting period, a long-term care hospital (including a satellite facility) discharges patients to an acute care hospital co-located with the long-term care hospital, as described in paragraph (a) of this section, and subsequently directly readmits more than 5 percent (that is, in excess of 5.0 percent) of the total number of its Medicare inpatients discharged from that acute care hospital, all such discharges to the co-located acute care hospital and the readmissions to the long-term care hospital will be treated as one discharge for that cost reporting period and one LTC–DRG payment will be made on the basis of each patient's initial principal diagnosis.

(d) If, during a cost reporting period, a long-term care hospital (including a satellite facility) discharges patients to an onsite IRF, an onsite psychiatric hospital or unit, or an onsite SNF, as described in paragraph (a) of this section, and subsequently directly readmits more than 5 percent (that is, in excess of 5.0 percent) of the total number of its Medicare inpatients discharged from the onsite IRF, the onsite psychiatric hospital or unit, or the onsite SNF, all such discharges to any of these providers and the readmissions to the LTCH will be treated as one discharge for that cost reporting period and one LTC–DRG payment will be made on the basis of the patient's initial principal diagnosis.

(e) For purposes of calculating the payment per discharge, payment for the entire stay at the long-term care hospital will be paid as a full LTC–DRG payment under § 412.523 or a short-stay outlier under § 412.529, depending on the duration of the entire stay.

(f) If the long-term care hospital does not meet the 5-percent thresholds specified under paragraph (c) or (d) of this section for discharges to the specified onsite providers and readmissions to the long-term care hospital during a cost reporting period, payment under the long-term care prospective payment system will be made, where applicable, under the policies on interruption of a stay as specified in § 412.531.

(g) Payment to the onsite acute care hospital, the onsite IRF, the onsite psychiatric hospital or unit, and the onsite SNF for a beneficiary's stay in the specified onsite providers is subject to the applicable payment policies, including outliers and transfers, under the acute care hospital inpatient prospective payment system, the IRF prospective payment system, the SNF prospective payment system, or the excluded psychiatric hospital or unit cost-based reimbursement payment system, as appropriate.

(h) In determining whether a patient has previously been discharged and

then admitted, all prior discharges are considered, even if the discharge occurs late in one cost reporting period and the readmission occurs late in next cost reporting period.

(i) A long-term care hospital or a satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days following the effective date of these regulations and within 60 days of a change in this co-located status.

§ 412.533 Transition payments.

(a) *Duration of transition periods.* Except for a long-term care hospital that makes an election under paragraph (c) of this section or for a long-term care hospital that is defined as new under § 412.23(e)(4), for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, a long-term care hospital receives a payment comprised of a blend of the adjusted Federal prospective payment as determined under § 412.523, and the payment determined under the cost-based reimbursement rules under Part 413 of this subchapter.

(1) For cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003, payment is based on 20 percent of the Federal prospective payment rate and 80 percent of the cost-based reimbursement rate.

(2) For cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004, payment is based on 40 percent of the Federal prospective payment rate and 60 percent of the cost-based reimbursement rate.

(3) For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005, payment is based on 60 percent of the Federal prospective payment rate and 40 percent of the cost-based reimbursement rate.

(4) For cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006, payment is based on 80 percent of the Federal prospective payment rate and 20 percent of the cost-based reimbursement rate.

(5) For cost reporting periods beginning on or after October 1, 2006, payment is based entirely on the adjusted Federal prospective payment rate.

(b) *Adjustments based on reconciliation of cost reports.* The cost-based percentage of the provider's total Medicare payment under paragraphs (a)(1) through (a)(4) of this section are subject to adjustments based on reconciliation of cost reports.

(c) *Election not to be paid under the transition period methodology.* A long-term care hospital may elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition periods specified in paragraph (a) of this section. Once a long-term care hospital elects to be paid based on 100 percent of the Federal prospective payment rate, it may not revert to the transition blend.

(1) *General requirement.* A long-term care hospital must notify its fiscal intermediary of its intent to elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period specified in paragraph (a) of this section.

(2) *Notification requirement to make election.*

(i) The request by the long-term care hospital to make the election under paragraph (c)(1) of this section must be made in writing to the Medicare fiscal intermediary.

(ii) For cost reporting periods that begin on or after October 1, 2002 through November 30, 2002, the fiscal intermediary must receive the notification of the election before November 1, 2002.

(iii) For cost reporting periods that begin on or after December 1, 2002 through September 30, 2006, the fiscal intermediary must receive the notification of the election on or before the 30th day before the applicable cost reporting period begins.

(iv) The fiscal intermediary must receive the notification by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section will not be accepted. If the date specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section falls on a day that the postal service or other delivery sources are not open for business, the long-term care hospital is responsible for allowing sufficient time for the delivery of the notification before the deadline.

(v) If a long-term care hospital's notification is not received by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, payment will be based on the transition period rates specified in paragraphs (a)(1) through (a)(5) of this section.

(d) *Payments to new long-term care hospitals.* A new long-term care hospital, as defined in § 412.23(e)(4), will be paid based on 100 percent of the standard Federal rate, as described in § 412.523, with no transition payments, as described in § 412.533(a)(1) through (a)(5).

§ 412.535 Publication of the Federal prospective payment rates.

CMS publishes information pertaining to the long-term care hospital prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the LTC–DRG classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.541 Method of payment under the long-term care hospital prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, long-term care hospitals receive payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.*

(1) *Criteria for receiving periodic interim payments.*

(i) A long-term care hospital receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the long-term care hospital must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) As provided in § 413.64(h)(5) of this subchapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of the PIP resulting in an overpayment to the provider.

(2) *Frequency of payment.*

(i) For long-term care hospitals approved for PIP and paid solely under Federal prospective payment system rates under § 412.533(b), the intermediary estimates the long-term care hospital's Federal prospective payments net after estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year.

(ii) For long-term care hospitals approved for PIP and paid using the blended payment schedule specified in § 412.533(a) for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, the intermediary estimates the hospital's portion of the Federal prospective payments net and the hospital's portion of the reasonable cost-based reimbursement payments net, after beneficiary deductibles and coinsurance, in accordance with the blended transition percentages specified in § 412.533(a), and makes biweekly payments equal to 1/26 of the total estimated amount of both portions of payments for the year.

(iii) If the long-term care hospital has payment experience under the long-term care hospital prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year.

(iv) Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter.

(v) The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the hospital.* Subject to paragraph (b)(1)(iii) of this section, a long-term care hospital receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the long-term care hospital no longer meets the requirements of § 413.64(h) of this subchapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for the costs of an approved education program, blood clotting factors, anesthesia services furnished by hospital-employed nonphysician anesthetists or obtained under arrangement, and photocopying and mailing medical records to a QIO, which are costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a long-term care hospital receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Special interim payment for unusually long lengths of stay.*

(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment 60 days after a Medicare beneficiary has been admitted to the hospital. Payment for the interim bill is determined as if the bill were a final discharge bill.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph.

(e) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(f) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to a long-term care hospital that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the long-term care hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A request by a long-term care hospital for an accelerated payment must be approved by the intermediary and by CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as long-term care hospital bills are processed or by direct payment by the long-term care hospital.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

2. Section 413.1 is amended by:

a. Revising paragraph (d)(2)(ii).

b. Adding paragraphs (d)(2)(vi) and (d)(2)(vii).

§ 413.1 Introduction.

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's and psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals) that are excluded from the prospective payment systems under subpart B of Part 412 of this subchapter and hospitals outside the 50 states and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 413.40.

* * * * *

(vi) For cost reporting periods beginning before October 1, 2002, payment to long-term care hospitals that are excluded under subpart B of Part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of § 413.40.

(vii) For cost reporting periods beginning on or after October 1, 2002, payment to the long-term hospitals that meet the condition for payment of §§ 412.505 through 412.511 of this subchapter is based on prospectively determined rates under subpart O of Part 412 of this subchapter.

* * * * *

Subpart C—Limits on Cost Reimbursement

3. Section 413.40 is amended by:

a. Republishing the introductory text of paragraph (a)(2)(i).

b. Adding a new paragraph (a)(2)(i)(D).

c. Amending paragraph (a)(2)(ii) by republishing the introductory text, removing ''and'' at the end of paragraph (a)(2)(ii)(A), removing the period and

adding ''; and'' at the end of paragraph (a)(2)(ii)(B), and adding a new paragraph (a)(2)(ii)(C).

d. Adding a new paragraph (a)(2)(iv).

§ 413.40 Ceiling on the rate of increase in hospital inpatient cost.

(a) *Introduction.* * * *

(2) *Applicability.* (i) This section is not applicable to—

* * * * *

(D) Long-term care hospitals, as defined in section 1886(d)(1)(B)(iv) of the Act, that are paid based on 100 percent of the Federal prospective payment rate for inpatient hospital services in accordance with section 123 of Public Law 106–113 and section 307 of Public Law 106–554 and § 412.533(b) and (c) of subpart O of Part 412 of this subchapter for cost reporting periods beginning on or after October 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to—

* * * * *

(C) Long-term care hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter and in accordance with § 412.23 of this subchapter, except as limited by paragraph (a)(2)(iv) of this section with respect to long-term care hospitals specified in § 412.23(e) of this subchapter.

* * * * *

(iv) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 2002, this section applies to long-term care hospitals that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter. For cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, this section also applies to long-term care hospitals, subject to paragraph (a)(2)(i)(D) of this section.

* * * * *

Subpart E—Payments to Providers

4. Section § 413.64 is amended as follows:

a. The introductory text of paragraph (h)(2) is republished.

b. Paragraph (h)(2)(i) and the introductory text of paragraph (h)(3) are revised.

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) *Periodic interim payment method of reimbursement—* * * *

(2) *Covered services furnished on or after July 1, 1987.* Effective with claims received on or after July 1, 1987, the periodic interim payment (PIP) method is available for the following:

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems described in § 412.1(a)(1) of this chapter, under subpart B of Part 412 of this subchapter or are paid under the prospective payment systems described in subparts O and P of Part 412 of this subchapter.

* * * * *

(3) Any participating provider furnishing the services described in paragraphs (h)(1) and (h)(2) of this section that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the intermediary finds administratively feasible:

* * * * *

PART 476—UTILIZATION AND QUALITY CONTROL REVIEW

1. The authority citation for Part 476 continues to read as follows:

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

2. Section 476.71 is amended by revising paragraph (c)(2) to read as follows:

§ 476.71 QIO review requirements.

* * * * *

(c) *Other duties and functions.* * * *

(2) As directed by CMS, the QIO must review changes in DRG and LTC–DRG assignments made by the intermediary under the provisions of §§ 412.60(d) and 412.513(c) of this chapter that result in the assignment of a higher-weighted DRG or a different LTC–DRG. The QIO's review must verify that the diagnostic and procedural information supplied by the hospital is substantiated by the information in the medical record.

* * * * *

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

Dated: August 21, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: August 21, 2002.

Tommy G. Thompson,

Secretary.

Addendum

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

Table 1.—Long-Term Care Hospital Wage Index for Urban Areas
Table 2.—Long-Term Care Hospital Wage Index for Rural Areas
Table 3.—LTC-DRG Relative Weights and Arithmetic Mean Length of Stay

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
0040	Abilene, TX	0.7965	0.9593
	Taylor, TX		
0060	Aguadilla, PR	0.4683	0.8937
	Aguada, PR		
	Aguadilla, PR		
	Moca, PR		
0080	Akron, OH	0.9739	0.9948
	Portage, OH		
	Summit, OH		
0120	Albany, GA	1.0606	1.0121
	Dougherty, GA		
	Lee, GA		
0160	Albany-Schenectady-Troy, NY	0.8452	0.9690
	Albany, NY		
	Montgomery, NY		
	Rensselaer, NY		
	Saratoga, NY		
	Schenectady, NY		
	Schoharie, NY		
0200	Albuquerque, NM	0.9723	0.9945
	Bernalillo, NM		
	Sandoval, NM		
	Valencia, NM		
0220	Alexandria, LA	0.8015	0.9603
	Rapides, LA		
0240	Allentown-Bethlehem-Easton, PA	1.0014	1.0003
	Carbon, PA		
	Lehigh, PA		
	Northampton, PA		
0280	Altoona, PA	0.9100	0.9820
	Blair, PA		
0320	Amarillo, TX	0.8671	0.9734
	Potter, TX		
	Randall, TX		
0380	Anchorage, AK	1.2569	1.0514
	Anchorage, AK		
0440	Ann Arbor, MI	1.0959	1.0192
	Lenawee, MI		
	Livingston, MI		
	Washtenaw, MI		
0450	Anniston, AL	0.8276	0.9655
	Calhoun, AL		
0460	Appleton-Oshkosh-Neenah, WI	0.9241	0.9848
	Calumet, WI		
	Outagamie, WI		
	Winnebago, WI		
0470	Arecibo, PR	0.4630	0.8926
	Arecibo, PR		
	Camuy, PR		
	Hatillo, PR		
0480	Asheville, NC	0.9174	0.9835
	Buncombe, NC		
	Madison, NC		
0500	Athens, GA	0.9842	0.9968
	Clarke, GA		
	Madison, GA		
	Oconee, GA		
0520	Atlanta, GA	1.0043	1.0009
	Barrow, GA		
	Bartow, GA		
	Carroll, GA		
	Cherokee, GA		
	Clayton, GA		
	Cobb, GA		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Coweta, GA		
	DeKalb, GA		
	Douglas, GA		
	Fayette, GA		
	Forsyth, GA		
	Fulton, GA		
	Gwinnett, GA		
	Henry, GA		
	Newton, GA		
	Paulding, GA		
	Pickens, GA		
	Rockdale, GA		
	Spalding, GA		
	Walton, GA		
0560	Atlantic-Cape May, NJ	1.1297	1.0259
	Atlantic, NJ		
	Cape May, NJ		
0580	Auburn-Opelika, AL	0.8230	0.9646
	Lee, AL		
0600	Augusta-Aiken, GA-SC	0.9975	0.9995
	Columbia, GA		
	McDuffie, GA		
	Richmond, GA		
	Aiken, SC		
	Edgefield, SC		
0640	Austin-San Marcos, TX	0.9597	0.9919
	Bastrop, TX		
	Caldwell, TX		
	Hays, TX		
	Travis, TX		
	Williamson, TX		
0680	Bakersfield, CA	0.9406	0.9881
	Kern, CA		
0720	Baltimore, MD	0.9805	0.9961
	Anne Arundel, MD		
	Baltimore, MD		
	Baltimore City, MD		
	Carroll, MD		
	Harford, MD		
	Howard, MD		
	Queen Anne's, MD		
0733	Bangor, ME	0.9580	0.9916
	Penobscot, ME		
0743	Barnstable-Yarmouth, MA	1.3626	1.0725
	Barnstable, MA		
0760	Baton Rouge, LA	0.8136	0.9627
	Ascension, LA		
	East Baton Rouge, LA		
	Livingston, LA		
	West Baton Rouge, LA		
0840	Beaumont-Port Arthur, TX	0.8428	0.9686
	Hardin, TX		
	Jefferson, TX		
	Orange, TX		
0860	Bellingham, WA	1.1826	1.0365
	Whatcom, WA		
0870	Benton Harbor, MI	0.8810	0.9762
	Berrien, MI		
0875	Bergen-Passaic, NJ	1.1681	1.0336
	Bergen, NJ		
	Passaic, NJ		
0880	Billings, MT	0.9365	0.9873
	Yellowstone, MT		
0920	Biloxi-Gulfport-Pascagoula, MS	0.8440	0.9688
	Hancock, MS		
	Harrison, MS		
	Jackson, MS		
0960	Binghamton, NY	0.8404	0.9681
	Broome, NY		
	Tioga, NY		
1000	Birmingham, AL	0.8775	0.9755
	Blount, AL		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Jefferson, AL		
	St. Clair, AL		
	Shelby, AL		
1010	Bismarck, ND	0.7984	0.9597
	Burleigh, ND		
	Morton, ND		
1020	Bloomington, IN	0.8842	0.9768
	Monroe, IN		
1040	Bloomington-Normal, IL	0.9038	0.9808
	McLean, IL		
1080	Boise City, ID	0.9051	0.9810
	Ada, ID		
	Canyon, ID		
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1349	1.0270
	Bristol, MA		
	Essex, MA		
	Middlesex, MA		
	Norfolk, MA		
	Plymouth, MA		
	Suffolk, MA		
	Worcester, MA		
	Hillsborough, NH		
	Merrimack, NH		
	Rockingham, NH		
	Strafford, NH		
1125	Boulder-Longmont, CO	0.9798	0.9960
	Boulder, CO		
1145	Brazoria, TX	0.8209	0.9642
	Brazoria, TX		
1150	Bremerton, WA	1.0758	1.0152
	Kitsap, WA		
1240	Brownsville-Harlingen-San Benito, TX	0.9004	0.9801
	Cameron, TX		
1260	Bryan-College Station, TX	0.9328	0.9866
	Brazos, TX		
1280	Buffalo-Niagara Falls, NY	0.9392	0.9878
	Erie, NY		
	Niagara, NY		
1303	Burlington, VT	0.9914	0.9983
	Chittenden, VT		
	Franklin, VT		
	Grand Isle, VT		
1310	Caguas, PR	0.4705	0.8941
	Caguas, PR		
	Cayey, PR		
	Cidra, PR		
	Gurabo, PR		
	San Lorenzo, PR		
1320	Canton-Massillon, OH	0.8904	0.9781
	Carroll, OH		
	Stark, OH		
1350	Casper, WY	0.9496	0.9899
	Natrona, WY		
1360	Cedar Rapids, IA	0.8699	0.9740
	Linn, IA		
1400	Champaign-Urbana, IL	0.9295	0.9859
	Champaign, IL		
1440	Charleston-North Charleston, SC	0.9204	0.9841
	Berkeley, SC		
	Charleston, SC		
	Dorchester, SC		
1480	Charleston, WV	0.9264	0.9853
	Kanawha, WV		
	Putnam, WV		
1520	Charlotte-Gastonia-Rock Hill, NC-SC	0.9312	0.9862
	Cabarrus, NC		
	Gaston, NC		
	Lincoln, NC		
	Mecklenburg, NC		
	Rowan, NC		
	Stanly, NC		
	Union, NC		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	York, SC		
1540	Charlottesville, VA	1.0501	1.0100
	Albemarle, VA		
	Charlottesville City, VA		
	Fluvanna, VA		
	Greene, VA		
1560	Chattanooga, TN-GA	0.9333	0.9867
	Catoosa, GA		
	Dade, GA		
	Walker, GA		
	Hamilton, TN		
	Marion, TN		
1580	Cheyenne, WY	0.8288	0.9658
	Laramie, WY		
1600	Chicago, IL	1.1008	1.0202
	Cook, IL		
	DeKalb, IL		
	DuPage, IL		
	Grundy, IL		
	Kane, IL		
	Kendall, IL		
	Lake, IL		
	McHenry, IL		
	Will, IL		
1620	Chico-Paradise, CA	0.9856	0.9971
	Butte, CA		
1640	Cincinnati, OH-KY-IN	0.9444	0.9889
	Dearborn, IN		
	Ohio, IN		
	Boone, KY		
	Campbell, KY		
	Gallatin, KY		
	Grant, KY		
	Kenton, KY		
	Pendleton, KY		
	Brown, OH		
	Clermont, OH		
	Hamilton, OH		
	Warren, OH		
1660	Clarksville-Hopkinsville, TN-KY	0.8306	0.9661
	Christian, KY		
	Montgomery, TN		
1680	Cleveland-Lorain-Elyria, OH	0.9429	0.9886
	Ashtabula, OH		
	Cuyahoga, OH		
	Geauga, OH		
	Lake, OH		
	Lorain, OH		
	Medina, OH		
1720	Colorado Springs, CO	0.9745	0.9949
	El Paso, CO		
1740	Columbia, MO	0.8674	0.9735
	Boone, MO		
1760	Columbia, SC	0.9474	0.9895
	Lexington, SC		
	Richland, SC		
1800	Columbus, GA-AL	0.8382	0.9676
	Russell, AL		
	Chattahoochee, GA		
	Harris, GA		
	Muscogee, GA		
1840	Columbus, OH	0.9543	0.9909
	Delaware, OH		
	Fairfield, OH		
	Franklin, OH		
	Licking, OH		
	Madison, OH		
	Pickaway, OH		
1880	Corpus Christi, TX	0.8337	0.9667
	Nueces, TX		
	San Patricio, TX		
1890	Corvallis, OR	1.1646	1.0329

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Benton, OR		
1900	Cumberland, MD-WV (WV Hospital)	0.8321	0.9664
	Allegany, MD		
	Mineral, WV		
1920	Dallas, TX	0.9855	0.9971
	Collin, TX		
	Dallas, TX		
	Denton, TX		
	Ellis, TX		
	Henderson, TX		
	Hunt, TX		
	Kaufman, TX		
	Rockwall, TX		
1950	Danville, VA	0.8613	0.9723
	Danville City, VA		
	Pittsylvania, VA		
1960	Davenport-Moline-Rock Island, IA-IL	0.8638	0.9728
	Scott, IA		
	Henry, IL		
	Rock Island, IL		
2000	Dayton-Springfield, OH	0.9151	0.9830
	Clark, OH		
	Greene, OH		
	Miami, OH		
	Montgomery, OH		
2020	Daytona Beach, FL	0.8952	0.9790
	Flagler, FL		
	Volusia, FL		
2030	Decatur, AL	0.8775	0.9755
	Lawrence, AL		
	Morgan, AL		
2040	Decatur, IL	0.7974	0.9595
	Macon, IL		
2080	Denver, CO	1.0280	1.0056
	Adams, CO		
	Arapahoe, CO		
	Denver, CO		
	Douglas, CO		
	Jefferson, CO		
2120	Des Moines, IA	0.8735	0.9747
	Dallas, IA		
	Polk, IA		
	Warren, IA		
2160	Detroit, MI	1.0413	1.0083
	Lapeer, MI		
	Macomb, MI		
	Monroe, MI		
	Oakland, MI		
	St. Clair, MI		
	Wayne, MI		
2180	Dothan, AL	0.7948	0.9590
	Dale, AL		
	Houston, AL		
2190	Dover, DE	1.0296	1.0059
	Kent, DE		
2200	Dubuque, IA	0.8519	0.9704
	Dubuque, IA		
2240	Duluth-Superior, MN-WI	1.0284	1.0057
	St. Louis, MN		
	Douglas, WI		
2281	Dutchess County, NY	1.0514	1.0103
	Dutchess, NY		
2290	Eau Claire, WI	0.8814	0.9763
	Chippewa, WI		
	Eau Claire, WI		
2320	El Paso, TX	0.9207	0.9841
	El Paso, TX		
2330	Elkhart-Goshen, IN	0.9638	0.9928
	Elkhart, IN		
2335	Elmira, NY	0.8415	0.9683
	Chemung, NY		
2340	Enid, OK	0.8357	0.9671

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Garfield, OK		
2360	Erie, PA	0.8633	0.9727
	Erie, PA		
2400	Eugene-Springfield, OR	1.1471	1.0294
	Lane, OR		
2440	Evansville-Henderson, IN-KY (IN Hospitals)	0.8489	0.9698
	Posey, IN		
	Vanderburgh, IN		
	Warrick, IN		
	Henderson, KY		
2520	Fargo-Moorhead, ND-MN	0.9268	0.9854
	Clay, MN		
	Cass, ND		
2560	Fayetteville, NC	0.9027	0.9805
	Cumberland, NC		
2580	Fayetteville-Springdale-Rogers, AR	0.8445	0.9689
	Benton, AR		
	Washington, AR		
2620	Flagstaff, AZ-UT	1.0553	1.0111
	Coconino, AZ		
	Kane, UT		
2640	Flint, MI	1.0844	1.0169
	Genesee, MI		
2650	Florence, AL	0.7845	0.9569
	Colbert, AL		
	Lauderdale, AL		
2655	Florence, SC	0.8693	0.9739
	Florence, SC		
2670	Fort Collins-Loveland, CO	1.0018	1.0004
	Larimer, CO		
2680	Ft. Lauderdale, FL	1.0293	1.0059
	Broward, FL		
2700	Fort Myers-Cape Coral, FL	0.9374	0.9875
	Lee, FL		
2710	Fort Pierce-Port St. Lucie, FL	1.0214	1.0043
	Martin, FL		
	St. Lucie, FL		
2720	Fort Smith, AR-OK	0.8052	0.9610
	Crawford, AR		
	Sebastian, AR		
	Sequoyah, OK		
2750	Fort Walton Beach, FL	0.9002	0.9800
	Okaloosa, FL		
2760	Fort Wayne, IN	0.9197	0.9839
	Adams, IN		
	Allen, IN		
	De Kalb, IN		
	Huntington, IN		
	Wells, IN		
	Whitley, IN		
2800	Forth Worth-Arlington, TX	0.9357	0.9871
	Hood, TX		
	Johnson, TX		
	Parker, TX		
	Tarrant, TX		
2840	Fresno, CA	0.9856	0.9971
	Fresno, CA		
	Madera, CA		
2880	Gadsden, AL	0.8792	0.9758
	Etowah, AL		
2900	Gainesville, FL	0.9255	0.9851
	Alachua, FL		
2920	Galveston-Texas City, TX	1.0262	1.0052
	Galveston, TX		
2960	Gary, IN	0.9529	0.9906
	Lake, IN		
	Porter, IN		
2975	Glens Falls, NY	0.8336	0.9667
	Warren, NY		
	Washington, NY		
2980	Goldsboro, NC	0.8709	0.9742
	Wayne, NC		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
2985	Grand Forks, ND-MN	0.9069	0.9814
	Polk, MN		
	Grand Forks, ND		
2995	Grand Junction, CO	0.9529	0.9906
	Mesa, CO		
3000	Grand Rapids-Muskegon-Holland, MI	0.9933	0.9987
	Allegan, MI		
	Kent, MI		
	Muskegon, MI		
	Ottawa, MI		
3040	Great Falls, MT	0.8870	0.9774
	Cascade, MT		
3060	Greeley, CO	0.9254	0.9851
	Weld, CO		
3080	Green Bay, WI	0.9208	0.9842
	Brown, WI		
3120	Greensboro-Winston-Salem-High Point, NC	0.9537	0.9907
	Alamance, NC		
	Davidson, NC		
	Davie, NC		
	Forsyth, NC		
	Guilford, NC		
	Randolph, NC		
	Stokes, NC		
	Yadkin, NC		
3150	Greenville, NC	0.9153	0.9831
	Pitt, NC		
3160	Greenville-Spartanburg-Anderson, SC	0.9151	0.9830
	Anderson, SC		
	Cherokee, SC		
	Greenville, SC		
	Pickens, SC		
	Spartanburg, SC		
3180	Hagerstown, MD	0.8365	0.9673
	Washington, MD		
3200	Hamilton-Middletown, OH	0.9287	0.9857
	Butler, OH		
3240	Harrisburg-Lebanon-Carlisle, PA	0.9285	0.9857
	Cumberland, PA		
	Dauphin, PA		
	Lebanon, PA		
	Perry, PA		
3283	Hartford, CT	1.1504	1.0301
	Hartford, CT		
	Litchfield, CT		
	Middlesex, CT		
	Tolland, CT		
3285	Hattiesburg, MS [2]	0.7476	0.9495
	Forrest, MS		
	Lamar, MS		
3290	Hickory-Morganton-Lenoir, NC	0.9367	0.9873
	Alexander, NC		
	Burke, NC		
	Caldwell, NC		
	Catawba, NC		
3320	Honolulu, HI	1.1538	1.0308
	Honolulu, HI		
3350	Houma, LA	0.7949	0.9590
	Lafourche, LA		
	Terrebonne, LA		
3360	Houston, TX	0.9623	0.9925
	Chambers, TX		
	Fort Bend, TX		
	Harris, TX		
	Liberty, TX		
	Montgomery, TX		
	Waller, TX		
3400	Huntington-Ashland, WV-KY-OH	0.9613	0.9923
	Boyd, KY		
	Carter, KY		
	Greenup, KY		
	Lawrence, OH		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Cabell, WV		
	Wayne, WV		
3440	Huntsville, AL	0.8883	0.9777
	Limestone, AL		
	Madison, AL		
3480	Indianapolis, IN	0.9676	0.9935
	Boone, IN		
	Hamilton, IN		
	Hancock, IN		
	Hendricks, IN		
	Johnson, IN		
	Madison, IN		
	Marion, IN		
	Morgan, IN		
	Shelby, IN		
3500	Iowa City, IA	0.9824	0.9965
	Johnson, IA		
3520	Jackson, MI	0.9257	0.9851
	Jackson, MI		
3560	Jackson, MS	0.8435	0.9687
	Hinds, MS		
	Madison, MS		
	Rankin, MS		
3580	Jackson, TN	0.9013	0.9803
	Madison, TN		
	Chester, TN		
3600	Jacksonville, FL	0.9213	0.9843
	Clay, FL		
	Duval, FL		
	Nassau, FL		
	St. Johns, FL		
3605	Jacksonville, NC	0.7622	0.9524
	Onslow, NC		
3610	Jamestown, NY	0.8050	0.9610
	Chautauqua, NY		
3620	Janesville-Beloit, WI	0.9739	0.9948
	Rock, WI		
3640	Jersey City, NJ	1.1162	1.0232
	Hudson, NJ		
3660	Johnson City-Kingsport-Bristol, TN-VA	0.8617	0.9723
	Carter, TN		
	Hawkins, TN		
	Sullivan, TN		
	Unicoi, TN		
	Washington, TN		
	Bristol City, VA		
	Scott, VA		
	Washington, VA		
3680	Johnstown, PA	0.8668	0.9734
	Cambria, PA		
	Somerset, PA		
3700	Jonesboro, AR	0.8439	0.9688
	Craighead, AR		
3710	Joplin, MO	0.8729	0.9746
	Jasper, MO		
	Newton, MO		
3720	Kalamazoo-Battlecreek, MI	1.0639	1.0128
	Calhoun, MI		
	Kalamazoo, MI		
	Van Buren, MI		
3740	Kankakee, IL	0.9889	0.9978
	Kankakee, IL		
3760	Kansas City, KS-MO	0.9501	0.9900
	Johnson, KS		
	Leavenworth, KS		
	Miami, KS		
	Wyandotte, KS		
	Cass, MO		
	Clay, MO		
	Clinton, MO		
	Jackson, MO		
	Lafayette, MO		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Platte, MO		
	Ray, MO		
3800	Kenosha, WI	0.9568	0.9914
	Kenosha, WI		
3810	Killeen-Temple, TX	0.8513	0.9703
	Bell, TX		
	Coryell, TX		
3840	Knoxville, TN	0.8873	0.9775
	Anderson, TN		
	Blount, TN		
	Knox, TN		
	Loudon, TN		
	Sevier, TN		
	Union, TN		
3850	Kokomo, IN	0.9126	0.9825
	Howard, IN		
	Tipton, IN		
3870	La Crosse, WI-MN	0.9244	0.9849
	Houston, MN		
	La Crosse, WI		
3880	Lafayette, LA	0.8499	0.9700
	Acadia, LA		
	Lafayette, LA		
	St. Landry, LA		
	St. Martin, LA		
3920	Lafayette, IN	0.9121	0.9824
	Clinton, IN		
	Tippecanoe, IN		
3960	Lake Charles, LA	0.7766	0.9553
	Calcasieu, LA		
3980	Lakeland-Winter Haven, FL	0.9067	0.9813
	Polk, FL		
4000	Lancaster, PA	0.9286	0.9857
	Lancaster, PA		
4040	Lansing-East Lansing, MI	0.9639	0.9928
	Clinton, MI		
	Eaton, MI		
	Ingham, MI		
4080	Laredo, TX	0.7849	0.9570
	Webb, TX		
4100	Las Cruces, NM	0.8619	0.9724
	Dona Ana, NM		
4120	Las Vegas, NV-AZ	1.1179	1.0236
	Mohave, AZ		
	Clark, NV		
	Nye, NV		
4150	Lawrence, KS	0.8656	0.9731
	Douglas, KS		
4200	Lawton, OK	0.8682	0.9736
	Comanche, OK		
4243	Lewiston-Auburn, ME	0.9267	0.9853
	Androscoggin, ME		
4280	Lexington, KY	0.8743	0.9749
	Bourbon, KY		
	Clark, KY		
	Fayette, KY		
	Jessamine, KY		
	Madison, KY		
	Scott, KY		
	Woodford, KY		
4320	Lima, OH	0.9470	0.9894
	Allen, OH		
	Auglaize, OH		
4360	Lincoln, NE	1.0168	1.0034
	Lancaster, NE		
4400	Little Rock-North Little Rock, AR	0.8957	0.9791
	Faulkner, AR		
	Lonoke, AR		
	Pulaski, AR		
	Saline, AR		
4420	Longview-Marshall, TX	0.8571	0.9714
	Gregg, TX		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Harrison, TX		
	Upshur, TX		
4480	Los Angeles-Long Beach, CA	1.1946	1.0389
	Los Angeles, CA		
4520	Louisville, KY-IN [1]	0.9457	0.9891
	Clark, IN		
	Floyd, IN		
	Harrison, IN		
	Scott, IN		
	Bullitt, KY		
	Jefferson, KY		
	Oldham, KY		
4600	Lubbock, TX	0.8432	0.9686
	Lubbock, TX		
4640	Lynchburg, VA	0.9104	0.9821
	Amherst, VA		
	Bedford, VA		
	Bedford City, VA		
	Campbell, VA		
	Lynchburg City, VA		
4680	Macon, GA	0.8839	0.9768
	Bibb, GA		
	Houston, GA		
	Jones, GA		
	Peach, GA		
	Twiggs, GA		
4720	Madison, WI	1.0360	1.0072
	Dane, WI		
4800	Mansfield, OH	0.8708	0.9742
	Crawford, OH		
	Richland, OH		
4840	Mayaguez, PR	0.4853	0.8971
	Anasco, PR		
	Cabo Rojo, PR		
	Hormigueros, PR		
	Mayaguez, PR		
	Sabana Grande, PR		
	San German, PR		
4880	McAllen-Edinburg-Mission, TX	0.8378	0.9676
	Hidalgo, TX		
4890	Medford-Ashland, OR	1.0314	1.0063
	Jackson, OR		
4900	Melbourne-Titusville-Palm Bay, FL	0.9913	0.9983
	Brevard, FL		
4920	Memphis, TN-AR-MS	0.8962	0.9792
	Crittenden, AR		
	DeSoto, MS		
	Fayette, TN		
	Shelby, TN		
	Tipton, TN		
4940	Merced, CA	0.9721	0.9944
	Merced, CA		
5000	Miami, FL	0.9967	0.9993
	Dade, FL		
5015	Middlesex-Somerset-Hunterdon, NJ	1.1407	1.0281
	Hunterdon, NJ		
	Middlesex, NJ		
	Somerset, NJ		
5080	Milwaukee-Waukesha, WI	0.9894	0.9979
	Milwaukee, WI		
	Ozaukee, WI		
	Washington, WI		
	Waukesha, WI		
5120	Minneapolis-St. Paul, MN-WI	1.0909	1.0182
	Anoka, MN		
	Carver, MN		
	Chisago, MN		
	Dakota, MN		
	Hennepin, MN		
	Isanti, MN		
	Ramsey, MN		
	Scott, MN		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Sherburne, MN		
	Washington, MN		
	Wright, MN		
	Pierce, WI		
	St. Croix, WI		
5140	Missoula, MT	0.9364	0.9873
	Missoula, MT		
5160	Mobile, AL	0.8027	0.9605
	Baldwin, AL		
	Mobile, AL		
5170	Modesto, CA	1.0820	1.0164
	Stanislaus, CA		
5190	Monmouth-Ocean, NJ	1.0863	1.0173
	Monmouth, NJ		
	Ocean, NJ		
5200	Monroe, LA	0.8149	0.9630
	Ouachita, LA		
5240	Montgomery, AL	0.7349	0.9470
	Autauga, AL		
	Elmore, AL		
	Montgomery, AL		
5280	Muncie, IN	0.9760	0.9952
	Delaware, IN		
5330	Myrtle Beach, SC	0.8759	0.9752
	Horry, SC		
5345	Naples, FL	0.9699	0.9940
	Collier, FL		
5360	Nashville, TN	0.9690	0.9938
	Cheatham, TN		
	Davidson, TN		
	Dickson, TN		
	Robertson, TN		
	Rutherford TN		
	Sumner, TN		
	Williamson, TN		
	Wilson, TN		
5380	Nassau-Suffolk, NY	1.3461	1.0692
	Nassau, NY		
	Suffolk, NY		
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2178	1.0436
	Fairfield, CT		
	New Haven, CT		
5523	New London-Norwich, CT	1.1525	1.0305
	New London, CT		
5560	New Orleans, LA	0.8995	0.9799
	Jefferson, LA		
	Orleans, LA		
	Plaquemines, LA		
	St. Bernard, LA		
	St. Charles, LA		
	St. James, LA		
	St. John The Baptist, LA		
	St. Tammany, LA		
5600	New York, NY	1.4305	1.0861
	Bronx, NY		
	Kings, NY		
	New York, NY		
	Putnam, NY		
	Queens, NY		
	Richmond, NY		
	Rockland, NY		
	Westchester, NY		
5640	Newark, NJ	1.1618	1.0324
	Essex, NJ		
	Morris, NJ		
	Sussex, NJ		
	Union, NJ		
	Warren, NJ		
5660	Newburgh, NY-PA	1.1113	1.0223
	Orange, NY		
	Pike, PA		
5720	Norfolk-Virginia Beach-Newport News, VA-NC	0.8538	0.9708

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City VA Williamsburg City, VA York, VA		
5775	Oakland, CA Alameda, CA Contra Costa, CA	1.5332	1.1066
5790	Ocala, FL Marion, FL	0.9556	0.9911
5800	Odessa-Midland, TX Ector, TX Midland, TX	1.0105	1.0021
5880	Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8655	0.9731
5910	Olympia, WA Thurston, WA	1.1362	1.0272
5920	Omaha, NE-IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	0.9677	0.9935
5945	Orange County, CA Orange, CA	1.1108	1.0222
5960	Orlando, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9603	0.9921
5990	Owensboro, KY Daviess, KY	0.8333	0.9667
6015	Panama City, FL Bay, FL	0.9061	0.9812
6020	Parkersburg-Marietta, WV-OH Washington, OH Wood, WV	0.8128	0.9626
6080	Pensacola, FL Escambia, FL Santa Rosa, FL	0.8331	0.9666
6120	Peoria-Pekin, IL Peoria, IL Tazewell, IL Woodford, IL	0.8635	0.9727
6160	Philadelphia, PA-NJ Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.0829	1.0166
6200	Phoenix-Mesa, AZ Maricopa, AZ Pinal, AZ	0.9610	0.9922

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
6240	Pine Bluff, AR	0.7925	0.9585
	Jefferson, AR		
6280	Pittsburgh, PA	0.9464	0.9893
	Allegheny, PA		
	Beaver, PA		
	Butler, PA		
	Fayette, PA		
	Washington, PA		
	Westmoreland, PA		
6323	Pittsfield, MA	1.0171	1.0034
	Berkshire, MA		
6340	Pocatello, ID	0.9448	0.9890
	Bannock, ID		
6360	Ponce, PR	0.5218	0.9044
	Guayanilla, PR		
	Juana Diaz, PR		
	Penuelas, PR		
	Ponce, PR		
	Villalba, PR		
	Yauco, PR		
6403	Portland, ME	0.9367	0.9873
	Cumberland, ME		
	Sagadahoc, ME		
	York, ME		
6440	Portland-Vancouver, OR-WA	1.1107	1.0221
	Clackamas, OR		
	Columbia, OR		
	Multnomah, OR		
	Washington, OR		
	Yamhill, OR		
	Clark, WA		
6483	Providence-Warwick-Pawtucket, RI	1.0768	1.0154
	Bristol, RI		
	Kent, RI		
	Newport, RI		
	Providence, RI		
	Washington, RI		
6520	Provo-Orem, UT	0.9836	0.9967
	Utah, UT		
6560	Pueblo, CO	0.8582	0.9716
	Pueblo, CO		
6580	Punta Gorda, FL	0.9014	0.9803
	Charlotte, FL		
6600	Racine, WI	0.9323	0.9865
	Racine, WI		
6640	Raleigh-Durham-Chapel Hill, NC	0.9774	0.9955
	Chatham, NC		
	Durham, NC		
	Franklin, NC		
	Johnston, NC		
	Orange, NC		
	Wake, NC		
6660	Rapid City, SD	0.8843	0.9769
	Pennington, SD		
6680	Reading, PA	0.9564	0.9913
	Berks, PA		
6690	Redding, CA	1.1136	1.0227
	Shasta, CA		
6720	Reno, NV	1.0369	1.0074
	Washoe, NV		
6740	Richland-Kennewick-Pasco, WA	1.0960	1.0192
	Benton, WA		
	Franklin, WA		
6760	Richmond-Petersburg, VA	0.9624	0.9925
	Charles City County, VA		
	Chesterfield, VA		
	Colonial Heights City, VA		
	Dinwiddie, VA		
	Goochland, VA		
	Hanover, VA		
	Henrico, VA		
	Hopewell City, VA		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	New Kent, VA		
	Petersburg City, VA		
	Powhatan, VA		
	Prince George, VA		
	Richmond City, VA		
6780	Riverside-San Bernardino, CA	1.1104	1.0221
	Riverside, CA		
	San Bernardino, CA		
6800	Roanoke, VA	0.8286	0.9657
	Botetourt, VA		
	Roanoke, VA		
	Roanoke City, VA		
	Salem City, VA		
6820	Rochester, MN	1.1474	1.0295
	Olmsted, MN		
6840	Rochester, NY	0.9200	0.9840
	Genesee, NY		
	Livingston, NY		
	Monroe, NY		
	Ontario, NY		
	Orleans, NY		
	Wayne, NY		
6880	Rockford, IL	0.9189	0.9838
	Boone, IL		
	Ogle, IL		
	Winnebago, IL		
6895	Rocky Mount, NC	0.9109	0.9822
	Edgecombe, NC		
	Nash, NC		
6920	Sacramento, CA	1.1769	1.0354
	El Dorado, CA		
	Placer, CA		
	Sacramento, CA		
6960	Saginaw-Bay City-Midland, MI	0.9526	0.9905
	Bay, MI		
	Midland, MI		
	Saginaw, MI		
6980	St. Cloud, MN	0.9844	0.9969
	Benton, MN		
	Stearns, MN		
7000	St. Joseph, MO	0.9009	0.9802
	Andrew, MO		
	Buchanan, MO		
7040	St. Louis, MO-IL	0.8882	0.9776
	Clinton, IL		
	Jersey, IL		
	Madison, IL		
	Monroe, IL		
	St. Clair, IL		
	Franklin, MO		
	Jefferson, MO		
	Lincoln, MO		
	St. Charles, MO		
	St. Louis, MO		
	St. Louis City, MO		
	Warren, MO		
7080	Salem, OR	1.0011	1.0002
	Marion, OR		
	Polk, OR		
7120	Salinas, CA	1.4674	1.0935
	Monterey, CA		
7160	Salt Lake City-Ogden, UT	0.9861	0.9972
	Davis, UT		
	Salt Lake, UT		
	Weber, UT		
7200	San Angelo, TX	0.8193	0.9639
	Tom Green, TX		
7240	San Antonio, TX	0.8547	0.9709
	Bexar, TX		
	Comal, TX		
	Guadalupe, TX		
	Wilson, TX		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
7320	San Diego, CA	1.1283	1.0257
	San Diego, CA		
7360	San Francisco, CA	1.4170	1.0834
	Marin, CA		
	San Francisco, CA		
	San Mateo, CA		
7400	San Jose, CA	1.4222	1.0844
	Santa Clara, CA		
7440	San Juan-Bayamon, PR	0.4748	0.8950
	Aguas Buenas, PR		
	Barceloneta, PR		
	Bayamon, PR		
	Canovanas, PR		
	Carolina, PR		
	Catano, PR		
	Ceiba, PR		
	Comerio, PR		
	Corozal, PR		
	Dorado, PR		
	Fajardo, PR		
	Florida, PR		
	Guaynabo, PR		
	Humacao, PR		
	Juncos, PR		
	Los Piedras, PR		
	Loiza, PR		
	Luguillo, PR		
	Manati, PR		
	Morovis, PR		
	Naguabo, PR		
	Naranjito, PR		
	Rio Grande, PR		
	San Juan, PR		
	Toa Alta, PR		
	Toa Baja, PR		
	Trujillo Alto, PR		
	Vega Alta, PR		
	Vega Baja, PR		
	Yabucoa, PR		
7460	San Luis Obispo-Atascadero-Paso Robles, CA	1.0990	1.0198
	San Luis Obispo, CA		
7480	Santa Barbara-Santa Maria-Lompoc, CA	1.0794	1.0159
	Santa Barbara, CA		
7485	Santa Cruz-Watsonville, CA	1.3970	1.0794
	Santa Cruz, CA		
7490	Santa Fe, NM	1.0196	1.0039
	Los Alamos, NM		
	Santa Fe, NM		
7500	Santa Rosa, CA	1.3004	1.0601
	Sonoma, CA		
7510	Sarasota-Bradenton, FL	1.0090	1.0018
	Manatee, FL		
	Sarasota, FL		
7520	Savannah, GA	0.9974	0.9995
	Bryan, GA		
	Chatham, GA		
	Effingham, GA		
7560	Scranton—Wilkes-Barre—Hazleton, PA	0.8682	0.9736
	Columbia, PA		
	Lackawanna, PA		
	Luzerne, PA		
	Wyoming, PA		
7600	Seattle-Bellevue-Everett, WA	1.1324	1.0265
	Island, WA		
	King, WA		
	Snohomish, WA		
7610	Sharon, PA	0.7924	0.9585
	Mercer, PA		
7620	Sheboygan, WI	0.8427	0.9685
	Sheboygan, WI		
7640	Sherman-Denison, TX	0.9373	0.9875
	Grayson, TX		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
7680	Shreveport-Bossier City, LA	0.9014	0.9803
	Bossier, LA		
	Caddo, LA		
	Webster, LA		
7720	Sioux City, IA-NE	0.8735	0.9747
	Woodbury, IA		
	Dakota, NE		
7760	Sioux Falls, SD	0.9095	0.9819
	Lincoln, SD		
	Minnehaha, SD		
7800	South Bend, IN	0.9929	0.9986
	St. Joseph, IN		
7840	Spokane, WA	1.0653	1.0131
	Spokane, WA		
7880	Springfield, IL	0.8654	0.9731
	Menard, IL		
	Sangamon, IL		
7920	Springfield, MO	0.8555	0.9711
	Christian, MO		
	Greene, MO		
	Webster, MO		
8003	Springfield, MA	1.0806	1.0161
	Hampden, MA		
	Hampshire, MA		
8050	State College, PA	0.9122	0.9824
	Centre, PA		
8080	Steubenville-Weirton, OH-WV (WV Hospitals)	0.8637	0.9727
	Jefferson, OH		
	Brooke, WV		
	Hancock, WV		
8120	Stockton-Lodi, CA	1.0785	1.0157
	San Joaquin, CA		
8140	Sumter, SC	0.7794	0.9559
	Sumter, SC		
8160	Syracuse, NY	0.9491	0.9898
	Cayuga, NY		
	Madison, NY		
	Onondaga, NY		
	Oswego, NY		
8200	Tacoma, WA	1.1611	1.0322
	Pierce, WA		
8240	Tallahassee, FL	0.8483	0.9697
	Gadsden, FL		
	Leon, FL		
8280	Tampa-St. Petersburg-Clearwater, FL	0.8908	0.9782
	Hernando, FL		
	Hillsborough, FL		
	Pasco, FL		
	Pinellas, FL		
8320	Terre Haute, IN	0.8498	0.9700
	Clay, IN		
	Vermillion, IN		
	Vigo, IN		
8360	Texarkana, AR-Texarkana, TX	0.8319	0.9664
	Miller, AR		
	Bowie, TX		
8400	Toledo, OH	0.9738	0.9948
	Fulton, OH		
	Lucas, OH		
	Wood, OH		
8440	Topeka, KS	0.8914	0.9783
	Shawnee, KS		
8480	Trenton, NJ	1.0383	1.0077
	Mercer, NJ		
8520	Tucson, AZ	0.8967	0.9793
	Pima, AZ		
8560	Tulsa, OK	0.8924	0.9785
	Creek, OK		
	Osage, OK		
	Rogers, OK		
	Tulsa, OK		
	Wagoner, OK		

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
8600	Tuscaloosa, AL	0.8171	0.9634
	Tuscaloosa, AL		
8640	Tyler, TX	0.9609	0.9922
	Smith, TX		
8680	Utica-Rome, NY	0.8311	0.9662
	Herkimer, NY		
	Oneida, NY		
8720	Vallejo-Fairfield-Napa, CA	1.3563	1.0713
	Napa, CA		
	Solano, CA		
8735	Ventura, CA	1.0996	1.0199
	Ventura, CA		
8750	Victoria, TX	0.8328	0.9666
	Victoria, TX		
8760	Vineland-Millville-Bridgeton, NJ	1.0441	1.0088
	Cumberland, NJ		
8780	Visalia-Tulare-Porterville, CA	0.9610	0.9922
	Tulare, CA		
8800	Waco, TX	0.8110	0.9622
	McLennan, TX		
8840	Washington, DC-MD-VA-WV	1.0962	1.0192
	District of Columbia, DC		
	Calvert, MD		
	Charles, MD		
	Frederick, MD		
	Montgomery, MD		
	Prince Georges, MD		
	Alexandria City, VA		
	Arlington, VA		
	Clarke, VA		
	Culpeper, VA		
	Fairfax, VA		
	Fairfax City, VA		
	Falls Church City, VA		
	Fauquier, VA		
	Fredericksburg City, VA		
	King George, VA		
	Loudoun, VA		
	Manassas City, VA		
	Manassas Park City, VA		
	Prince William, VA		
	Spotsylvania, VA		
	Stafford, VA		
	Warren, VA		
	Berkeley, WV		
	Jefferson, WV		
8920	Waterloo-Cedar Falls, IA	0.7980	0.9596
	Black Hawk, IA		
8940	Wausau, WI	0.9702	0.9940
	Marathon, WI		
8960	West Palm Beach-Boca Raton, FL	0.9778	0.9956
	Palm Beach, FL		
9000	Wheeling, WV-OH	0.7940	0.9588
	Belmont, OH		
	Marshall, WV		
	Ohio, WV		
9040	Wichita, KS	0.9545	0.9909
	Butler, KS		
	Harvey, KS		
	Sedgwick, KS		
9080	Wichita Falls, TX	0.7867	0.9573
	Archer, TX		
	Wichita, TX		
9140	Williamsport, PA	0.8497	0.9699
	Lycoming, PA		
9160	Wilmington-Newark, DE-MD	1.0804	1.0161
	New Castle, DE		
	Cecil, MD		
9200	Wilmington, NC	0.9408	0.9882
	New Hanover, NC		
	Brunswick, NC		
9260	Yakima, WA	1.0575	1.0115

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5 wage index [2]
	Yakima, WA		
9270	Yolo, CA	0.9696	0.9939
	Yolo, CA		
9280	York, PA	0.9372	0.9874
	York, PA		
9320	Youngstown-Warren, OH	0.9549	0.9910
	Columbiana, OH		
	Mahoning, OH		
	Trumbull, OH		
9340	Yuba City, CA	1.0359	1.0072
	Sutter, CA		
	Yuba, CA		
9360	Yuma, AZ	0.8989	0.9798
	Yuma, AZ		

[1] Pre-reclassification wage index from FY 2002 based on fiscal year 1998 audited inpatient acute-care hospital wage data that excludes wages for services provided by teaching physicians, interns and residents, and non-physician anesthetists under Part B of the Medicare program.

[2] One-fifth of the full wage index value. For example, for a LTCH located in Chicago, Illinois (MSA 1600) in FY 2003, the 1/5 of the wage index is computed as 5.1008/5 = 1.0202. For further details, see section X.J.1. of this final rule.

TABLE 2.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS

Nonurban area	Full wage index [1]	1/5 wage index [2]
Alabama	0.7332	0.9466
Alaska	1.1853	1.0371
Arizona	0.8675	0.9735
Arkansas	0.7488	0.9498
California	0.9772	0.9954
Colorado	0.8807	0.9761
Connecticut	1.2077	1.0415
Delaware	0.9581	0.9916
Florida	0.8812	0.9762
Georgia	0.8288	0.9658
Hawaii	1.1110	1.0222
Idaho	0.8702	0.9740
Illinois	0.8049	0.9610
Indiana	0.8720	0.9744
Iowa	0.8124	0.9625
Kansas	0.7754	0.9551
Kentucky	0.7958	0.9592
Louisiana	0.7596	0.9519
Maine	0.8716	0.9743
Maryland	0.8859	0.9772
Massachusetts	1.1454	1.0291
Michigan	0.9004	0.9801
Minnesota	0.9017	0.9803
Mississippi	0.7522	0.9504
Missouri	0.7772	0.9554
Montana	0.8649	0.9730
Nebraska	0.8111	0.9622
Nevada	0.9671	0.9934
New Hampshire	0.9736	0.9947
New Jersey [3]	.....	.....
New Mexico	0.8673	0.9735
New York	0.8515	0.9703
North Carolina	0.8536	0.9707
North Dakota	0.7856	0.9571
Ohio	0.8664	0.9733
Oklahoma	0.7565	0.9513
Oregon	1.0014	1.0003
Pennsylvania	0.8587	0.9717
Puerto Rico	0.4797	0.8959
Rhode Island [3]	.....	.....
South Carolina	0.8510	0.9702
South Dakota	0.7845	0.9569
Tennessee	0.7928	0.9586
Texas	0.7705	0.9541
Utah	0.9041	0.9808
Vermont	0.9462	0.9892
Virginia	0.8236	0.9647
Washington	1.0200	1.0040
West Virginia	0.8047	0.9609
Wisconsin	0.9069	0.9814
Wyoming	0.8736	0.9747

[1] Pre-reclassification wage index from FY 2002 based on fiscal year 1998 audited inpatient acute-care hospital wage data that excludes wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Part B of the Medicare program.

[2] One-fifth of the full wage index value. For example, for a LTCH located in rural Arizona in FY 2003, the 1/5 of the wage index is computed as 4.8675/5 = 0.9735. For further details, see section X.J.1 of this final rule.

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

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
1	CRANIOTOMY AGE >17 W CC[5]	1.8783	46.3	8
2	CRANIOTOMY AGE >17 W/O CC[5]	1.8783	46.3	1
3	CRANIOTOMY AGE 0–17*	1.8783	46.3	0
4	SPINAL PROCEDURES[4]	1.2493	31.3	16
5	EXTRACRANIAL VASCULAR PROCEDURES[4]	1.2493	31.3	5
6	CARPAL TUNNEL RELEASE*	0.4055	16.8	0
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.7829	43.8	97
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC[4]	1.2493	31.3	5
9	SPINAL DISORDERS & INJURIES	1.4118	34.6	130
10	NERVOUS SYSTEM NEOPLASMS W CC[7]	0.8537	24.5	102
11	NERVOUS SYSTEM NEOPLASMS W/O CC[7]	0.8537	24.5	26
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7773	27.1	1,577
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7207	25.6	89
14	INTERCRANIAL HEMORRHAGE & STROKE W INFARCT	0.8816	26.6	1,198
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION W/O INFARCT	0.9053	29.4	1,627
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.8864	27.0	120
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC[2]	0.6655	21.9	21
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7770	24.9	133
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.5486	22.0	43
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.2331	29.3	163
21	VIRAL MENINGITIS[1]	0.4055	16.8	7
22	HYPERTENSIVE ENCEPHALOPATHY[2]	0.6655	21.9	4
23	NONTRAUMATIC STUPOR & COMA	0.9623	27.2	85
24	SEIZURE & HEADACHE AGE >17 W CC	0.8831	24.8	123
25	SEIZURE & HEADACHE AGE >17 W/O CC	0.4830	20.4	47
26	SEIZURE & HEADACHE AGE 0–17*	0.4055	16.8	0
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1126	31.6	31
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.1507	29.0	134
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.9268	27.2	65
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17*	0.8284	23.3	0
31	CONCUSSION AGE >17 W CC[2]	0.6655	21.9	4
32	CONCUSSION AGE >17 W/O CC*	0.4055	16.8	0
33	CONCUSSION AGE 0–17*	0.4055	16.8	0
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8385	25.1	394
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6561	25.3	189
36	RETINAL PROCEDURES*	0.4055	16.8	0
37	ORBITAL PROCEDURES*	0.4055	16.8	0
38	PRIMARY IRIS PROCEDURES*	0.4055	16.8	0
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY*	0.4055	16.8	0
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17*	0.4055	16.8	0
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17*	0.4055	16.8	0
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS*	0.4055	16.8	0
43	HYPHEMA[3]	0.8284	23.3	2
44	ACUTE MAJOR EYE INFECTIONS[2]	0.6655	21.9	5
45	NEUROLOGICAL EYE DISORDERS[1]	0.4055	16.8	2
46	OTHER DISORDERS OF THE EYE AGE >17 W CC[2]	0.6655	21.9	14
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC[1]	0.4055	16.8	3
48	OTHER DISORDERS OF THE EYE AGE 0–17*	0.4055	16.8	0
49	MAJOR HEAD & NECK PROCEDURES*	1.8783	46.3	0
50	SIALOADENECTOMY*	0.6655	21.9	0
51	*	0.6655	21.9	0
52	CLEFT LIP & PALATE REPAIR*	0.6655	21.9	0
53	SINUS & MASTOID PROCEDURES AGE >17*	0.6655	21.9	0
54	SINUS & MASTOID PROCEDURES AGE 0–17*	0.6655	21.9	0
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES[2]	0.6655	21.9	1
56	RHINOPLASTY*	0.6655	21.9	0
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17*.	0.6655	21.9	0
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17*.	0.6655	21.9	0
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17*	0.6655	21.9	0
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17*	0.6655	21.9	0
61	MYRINGOTOMY W TUBE INSERTION AGE >17[5]	1.8783	46.3	1
62	MYRINGOTOMY W TUBE INSERTION AGE 0–17*	0.6655	21.9	0
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES[5]	1.8783	46.3	1
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.0447	25.5	111
65	DYSEQUILIBRIUM	0.5056	19.8	25
66	EPISTAXIS[1]	0.4055	16.8	3
67	EPIGLOTTITIS[1]	0.4055	16.8	1
68	OTITIS MEDIA & URI AGE >17 W CC[3]	0.8284	23.3	14

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
69	OTITIS MEDIA & URI AGE >17 W/O CC [3]	0.8284	23.3	8
70	OTITIS MEDIA & URI AGE 0–17 *	0.4055	16.8	0
71	LARYNGOTRACHEITIS *	0.4055	16.8	0
72	NASAL TRAUMA & DEFORMITY [1]	0.4055	16.8	2
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8097	23.7	29
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17 *	0.4055	16.8	0
75	MAJOR CHEST PROCEDURES [5]	1.8783	46.3	13
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7674	50.6	522
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC [5]	1.8783	46.3	14
78	PULMONARY EMBOLISM	0.6348	20.5	96
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8916	22.2	1,134
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.7947	22.8	123
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17 *	0.4055	16.8	0
82	RESPIRATORY NEOPLASMS	0.7976	20.9	402
83	MAJOR CHEST TRAUMA W CC	0.7384	24.8	25
84	MAJOR CHEST TRAUMA W/O CC [1]	0.4055	16.8	6
85	PLEURAL EFFUSION W CC	0.8207	23.6	163
86	PLEURAL EFFUSION W/O CC	0.6194	21.1	23
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6597	32.3	3,875
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7532	20.9	3,412
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.8533	23.6	2,654
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7921	23.0	318
91	SIMPLE PNEUMONIA & PLEURISY AGE 0–17 *	0.8284	23.3	0
92	INTERSTITIAL LUNG DISEASE W CC	0.7251	19.1	135
93	INTERSTITIAL LUNG DISEASE W/O CC	0.5573	18.5	29
94	PNEUMOTHORAX W CC	0.7885	22.7	41
95	PNEUMOTHORAX W/O CC [1]	0.4055	16.8	7
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.8173	24.2	147
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5940	17.9	23
98	BRONCHITIS & ASTHMA AGE 0–17 *	0.4055	16.8	0
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.1164	27.3	705
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	1.0015	25.4	77
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.9763	23.4	177
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.9313	24.5	28
103	HEART TRANSPLANT [6]	0.0000	0.0	0
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH *.	1.8783	46.3	0
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH *.	1.8783	46.3	0
106	CORONARY BYPASS W PTCA *	1.8783	46.3	0
107	CORONARY BYPASS W CARDIAC CATH *	1.8783	46.3	0
108	OTHER CARDIOTHORACIC PROCEDURES [2]	0.6655	21.9	1
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH *	1.8783	46.3	0
110	MAJOR CARDIOVASCULAR PROCEDURES W CC [5]	1.8783	46.3	5
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC [5]	1.8783	46.3	1
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	1.4103	36.9	92
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.3377	40.2	32
115	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P [5].	1.8783	46.3	3
116	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT [3].	0.8284	23.3	4
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT *	0.4055	16.8	0
118	CARDIAC PACEMAKER DEVICE REPLACEMENT [1]	0.4055	16.8	2
119	VEIN LIGATION & STRIPPING *	0.6655	21.9	0
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.4091	36.4	174
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7167	21.6	196
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	0.5144	19.0	51
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.9412	20.9	36
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG [3].	0.8284	23.3	5
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG [5].	1.8783	46.3	3
126	ACUTE & SUBACUTE ENDOCARDITIS	0.7689	24.8	148
127	HEART FAILURE & SHOCK	0.7616	22.4	2,324
128	DEEP VEIN THROMBOPHLEBITIS	0.6042	20.8	29
129	CARDIAC ARREST, UNEXPLAINED	1.0534	20.9	22
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7914	24.8	1,061
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.7081	23.7	178

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
132	ATHEROSCLEROSIS W CC	0.8183	21.8	645
133	ATHEROSCLEROSIS W/O CC	0.5484	18.5	126
134	HYPERTENSION	0.6985	24.0	123
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.7331	20.3	169
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.7075	21.0	24
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17*	0.6655	21.9	0
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7187	23.4	295
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.6482	20.4	54
140	ANGINA PECTORIS	0.7690	20.1	52
141	SYNCOPE & COLLAPSE W CC	0.6252	23.2	101
142	SYNCOPE & COLLAPSE W/O CC	0.5452	21.5	41
143	CHEST PAIN	0.7316	22.7	41
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7870	21.9	551
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.7637	25.0	66
146	RECTAL RESECTION W CC[4]	1.2493	31.3	1
147	RECTAL RESECTION W/O CC*	1.2493	31.3	0
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.8488	47.6	20
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC[2]	0.6655	21.9	3
150	PERITONEAL ADHESIOLYSIS W CC[1]	0.4055	16.8	1
151	PERITONEAL ADHESIOLYSIS W/O CC*	0.4055	16.8	0
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC[4]	1.2493	31.3	1
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC*	0.8284	23.3	0
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC[4]	1.2493	31.3	7
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC*.	0.8284	23.3	0
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17*	0.8284	23.3	0
157	ANAL & STOMAL PROCEDURES W CC[1]	0.4055	16.8	1
158	ANAL & STOMAL PROCEDURES W/O CC*	0.4055	16.8	0
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC[4]	1.2493	31.3	2
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC*.	0.6655	21.9	0
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC*	0.6655	21.9	0
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC*	0.6655	21.9	0
163	HERNIA PROCEDURES AGE 0–17*	0.6655	21.9	0
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC*	0.8284	23.3	0
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC*	0.8284	23.3	0
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC*	0.6655	21.9	0
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC*	0.6655	21.9	0
168	MOUTH PROCEDURES W CC[3]	0.8284	23.3	1
169	MOUTH PROCEDURES W/O CC*	0.6655	21.9	0
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.5543	35.0	40
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC[3]	0.8284	23.3	1
172	DIGESTIVE MALIGNANCY W CC	0.8553	24.2	335
173	DIGESTIVE MALIGNANCY W/O CC	0.5513	18.9	55
174	G.I. HEMORRHAGE W CC	0.8741	23.6	258
175	G.I. HEMORRHAGE W/O CC	0.8359	25.6	35
176	COMPLICATED PEPTIC ULCER	0.7661	24.4	37
177	UNCOMPLICATED PEPTIC ULCER W CC[3]	0.8284	23.3	14
178	UNCOMPLICATED PEPTIC ULCER W/O CC[2]	0.6655	21.9	6
179	INFLAMMATORY BOWEL DISEASE	1.0975	23.4	45
180	G.I. OBSTRUCTION W CC	0.8457	22.8	193
181	G.I. OBSTRUCTION W/O CC	0.5638	19.5	20
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8829	25.9	436
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.6913	21.5	66
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17*	0.6655	21.9	0
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17[3].	0.8284	23.3	20
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17*.	0.8284	23.3	0
187	DENTAL EXTRACTIONS & RESTORATIONS*	0.8284	23.3	0
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0490	24.2	481
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5852	17.4	48
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17*	0.6655	21.9	0
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC[5]	1.8783	46.3	5
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC*	1.2493	31.3	0
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC[4].	1.2493	31.3	1
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC*.	0.8284	23.3	0

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
195	CHOLECYSTECTOMY W C.D.E. W CC*	0.8284	23.3	0
196	CHOLECYSTECTOMY W C.D.E. W/O CC*	0.8284	23.3	0
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC[5]	1.8783	46.3	2
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC[5]	1.8783	46.3	2
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY[3]	0.8284	23.3	1
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY[4]	1.2493	31.3	3
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES[5]	1.8783	46.3	5
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.5736	18.4	64
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.5897	18.2	88
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9444	22.1	169
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.6825	21.5	85
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC[2]	0.6655	21.9	13
207	DISORDERS OF THE BILIARY TRACT W CC	0.6979	21.5	78
208	DISORDERS OF THE BILIARY TRACT W/O CC[1]	0.4055	16.8	20
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY[5].	1.8783	46.3	4
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC[4]	1.2493	31.3	12
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC*	0.8284	23.3	0
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17*	0.8284	23.3	0
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.2591	33.0	32
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE[4]	1.2493	31.3	8
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	1.3602	38.8	203
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC[3].	0.8284	23.3	4
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC*.	0.8284	23.3	0
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0–17*	0.8284	23.3	0
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC[4].	1.2493	31.3	1
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC[1].	0.4055	16.8	1
225	FOOT PROCEDURES[4]	1.2493	31.3	23
226	SOFT TISSUE PROCEDURES W CC[4]	1.2493	31.3	8
227	SOFT TISSUE PROCEDURES W/O CC[3]	0.8284	23.3	2
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC*	0.6655	21.9	0
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC[2]	0.6655	21.9	1
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR[1]	0.4055	16.8	1
231	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR[5].	1.8783	46.3	9
232	ARTHROSCOPY*	0.4055	16.8	0
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC[4]	1.2493	31.3	23
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC[1]	0.4055	16.8	2
235	FRACTURES OF FEMUR	0.7540	28.5	167
236	FRACTURES OF HIP & PELVIS	0.7381	27.2	1,451
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH[2]	0.6655	21.9	15
238	OSTEOMYELITIS	0.8275	27.5	947
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6689	21.9	199
240	CONNECTIVE TISSUE DISORDERS W CC	0.9260	26.0	100
241	CONNECTIVE TISSUE DISORDERS W/O CC	0.5805	22.7	40
242	SEPTIC ARTHRITIS	0.7725	26.3	174
243	MEDICAL BACK PROBLEMS	0.6596	23.4	765
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5756	20.6	337
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4426	17.5	376
246	NON-SPECIFIC ARTHROPATHIES	0.6053	21.4	45
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5590	20.4	324
248	TENDONITIS, MYOSITIS & BURSITIS	0.7288	23.9	277
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.8005	27.1	348
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.8373	31.8	120
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6904	26.0	55
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17*	0.4055	16.8	0
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.8054	28.0	225
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.6999	26.4	118
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17*	0.4055	16.8	0
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.8002	25.1	240
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC[2]	0.6655	21.9	3
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC*	0.6655	21.9	0

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC*	0.6655	21.9	0
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC*	0.6655	21.9	0
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION*.	0.4055	16.8	0
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY[1]	0.4055	16.8	1
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.5388	45.0	1,093
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.1645	38.8	115
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.6569	45.6	29
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC[3].	0.8284	23.3	5
267	PERIANAL & PILONIDAL PROCEDURES*	0.4055	16.8	0
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES[4]	1.2493	31.3	5
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3915	41.7	209
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	1.3879	41.6	22
271	SKIN ULCERS	0.9714	31.1	4,059
272	MAJOR SKIN DISORDERS W CC	0.6846	21.0	33
273	MAJOR SKIN DISORDERS W/O CC[2]	0.6655	21.9	11
274	MALIGNANT BREAST DISORDERS W CC[7]	0.7872	22.0	50
275	MALIGNANT BREAST DISORDERS W/O CC[7]	0.7872	22.0	11
276	NON-MALIGANT BREAST DISORDERS[2]	0.6655	21.9	8
277	CELLULITIS AGE >17 W CC	0.7704	24.4	985
278	CELLULITIS AGE >17 W/O CC	0.6353	22.4	247
279	CELLULITIS AGE 0–17*	0.6655	21.9	0
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	1.0097	30.9	161
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.7363	27.4	55
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17*	0.6655	21.9	0
283	MINOR SKIN DISORDERS W CC	0.8574	24.8	43
284	MINOR SKIN DISORDERS W/O CC[1]	0.4055	16.8	16
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	1.3692	31.7	25
286	ADRENAL & PITUITARY PROCEDURES*	1.2493	31.3	0
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.3195	39.6	52
288	O.R. PROCEDURES FOR OBESITY[5]	1.8783	46.3	3
289	PARATHYROID PROCEDURES*	0.4055	16.8	0
290	THYROID PROCEDURES[1]	0.4055	16.8	1
291	THYROGLOSSAL PROCEDURES*	0.4055	16.8	0
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC[4]	1.2493	31.3	17
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC*	0.6655	21.9	0
294	DIABETES AGE >35	0.7678	25.1	400
295	DIABETES AGE 0–35[3]	0.8284	23.3	6
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7710	24.3	648
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.6321	21.1	144
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17*	0.6655	21.9	0
299	INBORN ERRORS OF METABOLISM[3]	0.8284	23.3	12
300	ENDOCRINE DISORDERS W CC	0.8670	23.3	58
301	ENDOCRINE DISORDERS W/O CC[1]	0.4055	16.8	15
302	KIDNEY TRANSPLANT[6]	0.0000	0.0	0
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM[5]	1.8783	46.3	2
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC[4]	1.2493	31.3	10
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC[2]	0.6655	21.9	2
306	PROSTATECTOMY W CC[3]	0.8284	23.3	3
307	PROSTATECTOMY W/O CC[1]	0.4055	16.8	1
308	MINOR BLADDER PROCEDURES W CC[3]	0.8284	23.3	5
309	MINOR BLADDER PROCEDURES W/O CC*	0.4055	16.8	0
310	TRANSURETHRAL PROCEDURES W CC[4]	1.2493	31.3	6
311	TRANSURETHRAL PROCEDURES W/O CC[1]	0.4055	16.8	1
312	URETHRAL PROCEDURES, AGE >17 W CC[5]	1.8783	46.3	1
313	URETHRAL PROCEDURES, AGE >17 W/O CC*	0.4055	16.8	0
314	URETHRAL PROCEDURES, AGE 0–17*	0.4055	16.8	0
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.5800	39.5	221
316	RENAL FAILURE	0.9308	24.1	1,568
317	ADMIT FOR RENAL DIALYSIS[4]	1.2493	31.3	4
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.8075	21.5	69
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC[2]	0.6655	21.9	12
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7424	23.9	718
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.6123	20.4	111
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17*	0.6655	21.9	0
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY[2]	0.6655	21.9	11

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
324	URINARY STONES W/O CC[2]	0.6655	21.9	4
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.8123	26.7	24
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC[2]	0.6655	21.9	11
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17*	0.4055	16.8	0
328	URETHRAL STRICTURE AGE >17 W CC*	0.6655	21.9	0
329	URETHRAL STRICTURE AGE >17 W/O CC[1]	0.4055	16.8	1
330	URETHRAL STRICTURE AGE 0–17*	0.4055	16.8	0
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.9267	24.6	292
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6393	20.9	47
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17*	0.4055	16.8	0
334	MAJOR MALE PELVIC PROCEDURES W CC*	1.2493	31.3	0
335	MAJOR MALE PELVIC PROCEDURES W/O CC*	0.8284	23.3	0
336	TRANSURETHRAL PROSTATECTOMY W CC[3]	0.8284	23.3	2
337	TRANSURETHRAL PROSTATECTOMY W/O CC*	0.6655	21.9	0
338	TESTES PROCEDURES, FOR MALIGNANCY*	0.6655	21.9	0
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17[1]	0.4055	16.8	1
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17*	0.4055	16.8	0
341	PENIS PROCEDURES[2]	0.6655	21.9	1
342	CIRCUMCISION AGE >174[4]	1.2493	31.3	1
343	CIRCUMCISION AGE 0–17*	0.4055	16.8	0
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY[4].	1.2493	31.3	1
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY[3].	0.8284	23.3	2
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7070	21.6	51
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC[2]	0.6655	21.9	10
348	BENIGN PROSTATIC HYPERTROPHY W CC[1]	0.4055	16.8	3
349	BENIGN PROSTATIC HYPERTROPHY W/O CC*	0.4055	16.8	0
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6058	19.9	25
351	STERILIZATION, MALE*	0.4055	16.8	0
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES[3]	0.8284	23.3	9
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY*.	1.8783	46.3	0
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC*	1.2493	31.3	0
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC*	1.2493	31.3	0
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES*	1.2493	31.3	0
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY*	1.2493	31.3	0
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC[5]	1.8783	46.3	1
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC[1]	0.4055	16.8	2
360	VAGINA, CERVIX & VULVA PROCEDURES[1]	0.4055	16.8	2
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION*	0.6655	21.9	0
362	ENDOSCOPIC TUBAL INTERRUPTION*	0.6655	21.9	0
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY*	0.8284	23.3	0
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY*	0.6655	21.9	0
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES[5]	1.8783	46.3	2
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9654	23.9	71
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC[3]	0.8284	23.3	19
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM[4]	1.2493	31.3	13
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS[2]	0.6655	21.9	20
370	CESAREAN SECTION W CC*	0.8284	23.3	0
371	CESAREAN SECTION W/O CC*	0.6655	21.9	0
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES*	0.6655	21.9	0
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES*	0.4055	16.8	0
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C*	0.4055	16.8	0
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C*	0.4055	16.8	0
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE*	0.4055	16.8	0
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE*	0.4055	16.8	0
378	ECTOPIC PREGNANCY*	0.6655	21.9	0
379	THREATENED ABORTION*	0.4055	16.8	0
380	ABORTION W/O D&C*	0.4055	16.8	0
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY*	0.4055	16.8	0
382	FALSE LABOR*	0.4055	16.8	0
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS*	0.4055	16.8	0
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS*	0.4055	16.8	0
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY*.	0.4055	16.8	0
386	EXTREME IMMATURITY*	0.6655	21.9	0
387	PREMATURITY W MAJOR PROBLEMS*	0.6655	21.9	0
388	PREMATURITY W/O MAJOR PROBLEMS*	0.4055	16.8	0
389	FULL TERM NEONATE W MAJOR PROBLEMS[4]	1.2493	31.3	1

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
390	NEONATE W OTHER SIGNIFICANT PROBLEMS*	0.6655	21.9	0
391	NORMAL NEWBORN*	0.4055	16.8	0
392	SPLENECTOMY AGE >17*	0.8284	23.3	0
393	SPLENECTOMY AGE 0–17*	0.6655	21.9	0
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS[5].	1.8783	46.3	4
395	RED BLOOD CELL DISORDERS AGE >17	0.8584	25.1	131
396	RED BLOOD CELL DISORDERS AGE 0–17*	0.4055	16.8	0
397	COAGULATION DISORDERS	0.7567	19.4	24
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9008	23.4	49
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC[1]	0.4055	16.8	5
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE[3]	0.8284	23.3	1
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC[4]	1.2493	31.3	7
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC*	0.8284	23.3	0
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.9651	23.9	185
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8980	19.1	23
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17*	0.6655	21.9	0
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC[5].	1.8783	46.3	1
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC*.	0.8284	23.3	0
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC[4]	1.2493	31.3	5
409	RADIOTHERAPY	0.5220	19.5	22
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS[1] ..	0.4055	16.8	11
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY*	0.4055	16.8	0
412	HISTORY OF MALIGNANCY W ENDOSCOPY*	0.4055	16.8	0
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC[7]	0.9061	23.7	63
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC[7]	0.9061	23.7	8
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.4933	38.7	262
416	SEPTICEMIA AGE >17	0.9612	25.9	1,722
417	SEPTICEMIA AGE 0–17*	0.8284	23.3	0
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8771	25.8	564
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.5948	20.5	20
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC[1]	0.4055	16.8	9
421	VIRAL ILLNESS AGE >17[4]	1.2493	31.3	15
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17*	0.4055	16.8	0
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.8701	24.7	190
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS[5]	1.8783	46.3	11
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.6177	26.0	54
426	DEPRESSIVE NEUROSES	0.5739	26.9	74
427	NEUROSES EXCEPT DEPRESSIVE[2]	0.6655	21.9	12
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL[4]	1.2493	31.3	17
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5466	25.0	535
430	PSYCHOSES	0.4479	22.9	1,667
431	CHILDHOOD MENTAL DISORDERS	0.4345	22.7	27
432	OTHER MENTAL DISORDER DIAGNOSES[2]	0.6655	21.9	4
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2489	13.1	10
439	SKIN GRAFTS FOR INJURIES	1.3200	42.5	28
440	WOUND DEBRIDEMENTS FOR INJURIES	1.3567	40.1	90
441	HAND PROCEDURES FOR INJURIES*	0.6655	21.9	0
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.6442	39.7	37
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC[2]	0.6655	21.9	4
444	TRAUMATIC INJURY AGE >17 W CC	0.9614	30.7	363
445	TRAUMATIC INJURY AGE >17 W/O CC	0.8448	27.3	80
446	TRAUMATIC INJURY AGE 0–17*	0.8284	23.3	0
447	ALLERGIC REACTIONS AGE >17[2]	0.6655	21.9	4
448	ALLERGIC REACTIONS AGE 0–17*	0.4055	16.8	0
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC[3]	0.8284	23.3	16
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC[2]	0.6655	21.9	7
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17*	0.4055	16.8	0
452	COMPLICATIONS OF TREATMENT W CC	0.9596	25.5	356
453	COMPLICATIONS OF TREATMENT W/O CC	0.6666	23.1	52
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC[3]	0.8284	23.3	15
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC[1]	0.4055	16.8	4
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.3383	38.0	253
462	REHABILITATION	0.6469	23.5	7,016
463	SIGNS & SYMPTOMS W CC	0.7618	26.8	1,318
464	SIGNS & SYMPTOMS W/O CC	0.6234	24.3	570
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS[3]	0.8284	23.3	18
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.8119	23.9	160

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
467	OTHER FACTORS INFLUENCING HEALTH STATUS[2]	0.6655	21.9	7
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2177	45.5	555
469	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS[6]	0.0000	0.0	0
470	UNGROUPABLE[6]	0.0000	0.0	0
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY*.	1.8783	46.3	0
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8047	17.1	18
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0906	35.5	5,224
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS[5]	1.8783	46.3	21
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.6791	39.7	189
478	OTHER VASCULAR PROCEDURES W CC	1.6244	37.8	45
479	OTHER VASCULAR PROCEDURES W/O CC[2]	0.6655	21.9	2
480	LIVER TRANSPLANT[6]	0.0000	0.0	0
481	BONE MARROW TRANSPLANT*	1.8783	46.3	0
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES*	0.6655	21.9	0
483	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG.	3.2319	54.6	403
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA*	1.8783	46.3	0
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR*.	1.8783	46.3	0
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA[3]	0.8284	23.3	3
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.0885	29.5	94
488	HIV W EXTENSIVE O.R. PROCEDURE[5]	1.8783	46.3	6
489	HIV W MAJOR RELATED CONDITION	0.8846	22.9	100
490	HIV W OR W/O OTHER RELATED CONDITION	0.6952	20.4	20
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY*.	1.8783	46.3	0
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS[3]	0.8284	23.3	1
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC[3]	0.8284	23.3	4
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC[1]	0.4055	16.8	1
495	LUNG TRANSPLANT[6]	0.0000	0.0	0
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION*	1.2493	31.3	0
497	SPINAL FUSION W CC[5]	1.8783	46.3	3
498	SPINAL FUSION W/O CC[3]	0.8284	23.3	1
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC[5]	1.8783	46.3	2
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC*	0.8284	23.3	0
501	KNEE PROCEDURES W PDX OF INFECTION W CC[5]	1.8783	46.3	3
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC*	0.8284	23.3	0
503	KNEE PROCEDURES W/O PDX OF INFECTION[5]	1.8783	46.3	3
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT*	1.8783	46.3	0
505	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT[4]	1.2493	31.3	6
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA[5].	1.8783	46.3	9
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA*.	0.8284	23.3	0
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA[3].	0.8284	23.3	20
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA[3].	0.8284	23.3	10
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.0734	32.2	31
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA[3]	0.8284	23.3	8
512	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT[6]	0.0000	0.0	0
513	PANCREAS TRANSPLANT[6]	0.0000	0.0	0
514	CARDIAC DEFIBRILATOR IMPLANT W CARDIAC CATH*	0.8284	23.3	0
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH[4]	1.2493	31.3	4
516	PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI*	0.8284	23.3	0
517	PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI[5].	1.8783	46.3	1
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI[4].	1.2493	31.3	1
519	CERVICAL SPINAL FUSION W CC[3]	0.8284	23.3	2
520	CERVICAL SPINAL FUSION W/O CC[2]	0.6655	21.9	1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.3755	18.6	133
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC[1].	0.4055	16.8	22
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.3860	21.2	72
524	TRANSIENT ISCHEMIA	0.6250	23.1	124
525	HEART ASSIST SYSTEM IMPLANT*	1.8783	46.3	0

TABLE 3.—LTC–DRG RELATIVE WEIGHTS AND ARITHMETIC MEAN LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geo-metric mean length of stay	FY 2001 LTCH cases
526	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI*.	0.8284	23.3	0
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI*.	0.8284	23.3	0

*Relative weights for these LTC–DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2001 MedPAR.
[1] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 1.
[2] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 2.
[3] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 3.
[4] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 4.
[5] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 5.
[6] Relative weights for these LTC–DRGs were assigned a value of 0.0.
[7] Relative weights for these LTC–DRGs were determined after adjusting to account for nonmonotonically (see step 5 above).

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

Appendix A—Market Basket for LTCHs

A market basket has historically been used under the Medicare program to account for price increases of the services furnished by providers. The market basket used for the LTCH prospective payment system includes both operating and capital-related costs of LTCHs because we are implementing a single payment rate for both operating and capital-related costs (section X.K.. of this final rule). Under the reasonable cost-based TEFRA reimbursement system, the excluded hospital market basket is used to update limits on payment for operating costs for LTCHs. The excluded hospital market basket is based on operating costs from 1992 cost report data and includes Medicare-participating long-term care, rehabilitation, psychiatric, cancer, and children's hospitals. Since LTCH's costs are included in the excluded hospital market basket, this index, in part, reflects the cost shares of LTCHs. However, in order to capture the total costs (operating and capital) of LTCHs, we are adding a capital component to the excluded hospital market basket for use under the LTCH prospective payment system. We refer to this index as the excluded hospital with capital market basket.

At this time, we are not implementing a separate market basket for LTCHs because, currently, we believe that we may not have sufficient LTCH data to develop an accurate market basket based only on the costs of LTCHs. Since the excluded hospital market basket is currently used under the reasonable cost-based (TEFRA) payment system for LTCHs, we believe it is appropriate to use that market basket (including a component for capital costs) for LTCHs under the LTCH prospective payment system. The same excluded hospital with capital market basket is used under the IRF prospective payment system.

In the following discussion, we describe the methodology used to determine the operating and capital portions of the market basket, and include additional analyses explaining the extent to which long-term care cost shares are reflected in the excluded hospital with capital market basket.

The operating portion of the excluded hospital with capital market basket consists of major cost categories and their respective weights. The major cost categories include wages and salaries, employee benefits, pharmaceuticals, and a residual. The weights for the major cost categories are developed from the Medicare cost reports for FY 1992. The cost report data used include those hospitals excluded from the hospital inpatient prospective payment system when the Medicare average length of stay is within 15 percent (higher or lower) of the total facility average length of stay. Using the 15-percent threshold resulted in a subset of hospitals that have a significant amount of Medicare days and costs compared to using no adjustment or using a different threshold. Limiting the sample in this way provides a more accurate reflection of the structure of costs of treating Medicare patients. We compared the average length of stay for all patients to that of Medicare beneficiaries as a test of the similarity of the practice patterns for non-Medicare patients versus Medicare patients. Our goal was to measure cost shares that were reflective of the case-mix and practice patterns associated with providing services to Medicare beneficiaries (61 FR 46196, August 30, 1996). We chose to limit the data in the database because we use facility-wide data to calculate the cost shares. Including facilities' costs that are significantly reflective of the non-Medicare case-mix would inappropriately skew the data and would not be reflective of the case-mix and practice patterns associated with Medicare patients. We accomplished our goal by limiting the reports we used to those with similar length of stays for the Medicare and total facility populations. The detailed cost categories under the residual are derived from the Asset and Expenditure Survey, 1992 Census of Service Industries, by the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce. This survey is used in conjunction with the 1992 Input-Output Tables published by the Bureau of Economic Analysis, U.S. Department of Commerce. A more detailed description of the development of the operating portion of this index can be found in the final rule, ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates,'' published in the **Federal Register** on August 29, 1997 (62 FR 45993–45997).

As previously stated, the market basket for the LTCH prospective payment system reflects both operating and capital-related costs. Capital-related costs include depreciation, interest, and other associated capital-related costs. The cost categories for the capital portion of the excluded hospital with capital market basket are developed in a similar manner as those for the capital input price index used under the acute care hospital inpatient prospective payment system for capital-related costs, which is explained in the August 30, 1996 **Federal Register** (61 FR 46196–46197). We calculated weights for capital costs using the same set of Medicare cost reports used to develop the operating share. The resulting capital weight for the FY 1992 base year is 9.080 percent.

Because capital is consumed over time, depreciation and interest costs in the current year reflect both current and previous capital purchases. We use vintage weighting to capture this effect. Vintage weighting, which is explained in the August 30, 1996 **Federal Register** (61 FR 46197–46203), is the process of weighting price changes for individual years in proportion to that year's share of total purchases still being consumed.

In order to vintage weight the capital portion of the index as described above, the average useful life of both assets and debt instruments (for example, a loan, bond, or promissory note) needs to be developed. For depreciation expenses, the useful life of fixed and movable assets is calculated from the Medicare cost reports for excluded hospitals, including LTCHs. The average useful life for fixed assets is 21 years, and the average useful life for movable assets is 13 years. For interest expenses, we use the same useful life of debt instruments used in the acute care hospital inpatient prospective payment system capital input price index. We believe that this useful life is appropriate because it reflects the average useful life of hospital issuances of commercial and municipal bonds from all hospitals, including LTCHs. The average useful life of interest expense is determined to be 22 years (61 FR 46199). After the useful life is determined, a set of weights is calculated by determining the average proportion of depreciation and interest expense incurred in any given year over the useful life. This information is developed using the Medicare cost reports. These calculations are the same as those described for the capital input price index used under the acute care hospital inpatient prospective payment system for capital-related costs discussed in the August 30, 1996 hospital inpatient prospective payment system final rule (61 FR 46196–46198). The price proxies for each of the capital cost categories are the same as those used for the capital input price index used under the acute care hospital inpatient prospective payment system for capital-related costs. The cost categories, price proxies, and base-year FY 1992 weights for the excluded hospital with capital market basket that will be used under the LTCH prospective payment system are presented in Table 1 below. The vintage weights for the index are presented in Table 2 below.

TABLE 1.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1992) STRUCTURE AND WEIGHTS

Cost category	Price/Wage Variable	Weights (%) Base-Year: 1992
Total		100.000
Compensation		57.935
Wages and Salaries	CMS Occupational Wage Proxy	47.417
Employee Benefits	CMS Occupational Benefit Proxy	10.519
Professional fees: Non-Medical	ECI—Compensation: Prof. & Technical	1.908
Utilities		1.524
Electricity	WPI—Commercial Electric Power	0.916

TABLE 1.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1992) STRUCTURE AND WEIGHTS—Continued

Cost category	Price/Wage Variable	Weights (%) Base-Year: 1992
Fuel Oil, Coal etc.	WPI—Commercial Natural Gas	0.365
Water and Sewerage	CPI–U—Water & Sewage	0.243
Professional Liability Insurance	CMS—Professional Liability Premiums	0.983
All Other Products and Services		28.571
All Other Products		22.027
Pharmaceuticals	WPI—Prescription Drugs	2.791
Food: Direct Purchase	WPI—Processed Foods	2.155
Food: Contract Service	CPI–U—Food Away from Home	0.998
Chemicals	WPI—Industrial Chemicals	3.413
Medical Instruments	WPI—Med. Inst. & Equipment	2.868
Photographic Supplies	WPI—Photo Supplies	0.364
Rubber and Plastics	WPI—Rubber & Plastic Products	4.423
Paper Products	WPI—Convert. Paper and Paperboard	1.984
Apparel	WPI—Apparel	0.809
Machinery and Equipment	WPI—Machinery & Equipment	0.193
Miscellaneous Products	WPI—Finished Goods	2.029
All Other Services		6.544
Telephone	CPI–U—Telephone Services	0.574
Postage	CPI–U—Postage	0.268
All Other: Labor	ECI—Compensation: Service Workers	4.945
All Other: Non-Labor Intensive	CPI–U—All Items (Urban)	0.757
Capital-Related Costs		9.080
Depreciation		5.611
Fixed Assets	Boeckh-Institutional Construction: 21 Year Useful Life	3.570
Movable Equipment	WPI—Machinery & Equipment: 13 Year Useful Life	2.041
Interest Costs		3.212
Non-profit	Avg. Yield Municipal Bonds: 22 Year Useful Life	2.730
For-profit	Avg. Yield AAA Bonds: 22 Year Useful Life	0.482
Other Capital-Related Costs	CPI–U—Residential Rent	0.257

*The wage and benefit proxies are a blend of 10 employment cost indices (ECI). A detailed discussion of the price proxies can be found in the August 30, 1996 and August 29, 1997 **Federal Register** final rules (61 FR 46197 and 62 FR 45993). The operating cost categories in the excluded market basket described in August 29, 1997 **Federal Register** (62 FR 45993 through 45996) had weights that added to 100.0. When we add an additional set of cost category weights (capital weight = 9.08 percent) to this original group, the sum of the weights in the new index must still add to 100.0. If capital cost category weights sum to 9.08, then operating cost category weights must add to 90.92 percent. Each weight in the excluded hospital market basket from the August 29, 1997 **Federal Register** (62 FR 45996 through 45997) was multiplied by 0.9092 to determine its weight in the excluded hospital with capital market basket.

TABLE 2.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1992) VINTAGE WEIGHTS

Year	Fixed assets (21-year weights)	Movable assets (13-year weights)	Interest: Capital-related (22-year weights)
1	0.0201	0.0454	0.0071
2	0.0225	0.0505	0.0082
3	0.0225	0.0562	0.0100
4	0.0285	0.0620	0.0119
5	0.0301	0.0660	0.0139
6	0.0321	0.0710	0.0161
7	0.0336	0.0764	0.0185
8	0.0353	0.0804	0.0207
9	0.0391	0.0860	0.0244
10	0.0431	0.0923	0.0291
11	0.0474	0.0987	0.0350
12	0.0513	0.1047	0.0409
13	0.0538	0.1104	0.0474
14	0.0561	.....	0.0525
15	0.0600	.....	0.0590
16	0.0628	.....	0.0670
17	0.0658	.....	0.0742
18	0.0695	.....	0.0809
19	0.0720	.....	0.0875
20	0.0748	.....	0.0931
21	0.0769	.....	0.0993
22	.....	.....	0.1034
Total	1.0000	1.0000	1.0000

We further analyzed the extent to which the weights in the excluded hospital with capital market basket reflect the cost weights in LTCHs, particularly since more than 50 percent of excluded hospitals are psychiatric hospitals. For this purpose, we conducted an analysis comparing the major cost weights for LTCHs to the same set of cost weights for excluded hospitals. We analyzed the variations of wages, drugs, and capital. This analysis showed that these weights differed only slightly between the different types of hospitals. When the LTCH weights were substituted into the market basket structure for sensitivity analysis, the effect was less than 0.2 percentage points in any given year. This difference is less than the 0.25 percentage point criterion that determines whether a forecast error adjustment under the acute care hospital inpatient prospective payment system is warranted. In addition, many LTCHs specialize in rehabilitation or psychiatric services. Thus, it would be anticipated that the cost shares would not differ significantly from these other types of excluded hospitals. Based on this analysis, we believe that using the excluded hospital with capital market basket for the LTCH prospective payment system provides a reasonable measure of the price changes facing LTCHs. In the March 22, 2002 proposed rule, we requested comments on any other data sources that may be available to provide detailed cost category information on LTCHs. We received no comments in response to this request.

Appendix B—Update Framework

Section 307(b) of Public Law 106–554 requires that the Secretary examine the appropriateness of certain adjustments to the LTCH prospective payment, including updates. Updates are necessary to appropriately account for changes in the prices of goods and services used by a provider in furnishing care to patients. A market basket has historically been used under the Medicare program in setting update factors for services furnished by providers. Beginning in FY 2004, the annual update to the standard Federal rate for the LTCH prospective payment system

(described in section X.K.2. of this final rule) will be equal to the percentage change in the excluded hospital with capital market basket index described in Appendix A of this final rule. However, in the future we may propose to develop an update framework to update payments to LTCHs that will account for other appropriate factors that affect the efficient delivery of services and care provided to Medicare patients. The update framework would be proposed in accordance with the notice and comment rulemaking process. While we are not implementing a specific update framework for the LTCH prospective payment system at this time in this final rule, we are providing a conceptual basis for developing such an update framework.

A. Need for an Update Framework

Under the LTCH prospective payment system, Medicare payments to LTCHs are based on a predetermined national payment amount per discharge. Under section 123 of the BBRA and section 307(b) of the BIPA, the Secretary has broad authority to make appropriate adjustments to the LTCH payment system, including updates to the payment rates. Our goal is to develop a method for analyzing and comparing expected trends in the underlying cost per discharge to use in establishing these updates. However, as stated earlier, until an appropriate update framework is developed, future updates will be based only on the increase in the excluded hospital with capital market basket.

The market basket for the LTCH prospective payment system (the excluded hospital with capital market basket), developed by our Office of the Actuary (OACT), represents only one component in the measure of growth in LTCHs' costs per discharge. It captures only the pure price change of inputs (labor, materials, and capital) used by the hospital to produce a constant quantity and quality of care. However, other factors also contribute to the change in costs per discharge, including changes in case-mix, intensity, and productivity.

Under the acute care hospital inpatient prospective payment system, we use an update framework to account for these other factors and to make annual recommendations to the Congress concerning the magnitude of the update. We are currently examining these factors and exploring ways that they could be measured and incorporated into an update framework for the LTCH prospective payment system. We are also examining additional conceptual and data issues that must be considered when the framework is constructed and applied.

At this time, we have established a future annual update that is equal to the excluded hospital with capital market basket used under the LTCH prospective payment system described in Appendix A of this final rule. We believe an annual update based on the market basket described in this final rule will provide for a reasonable update until a more comprehensive update framework can be developed. Currently, under the TEFRA system, the excluded hospital market basket is used as the basis for updates to LTCHs' target amounts for inpatient operating costs. While our experience in developing other update frameworks, such as the acute care hospital inpatient (operating and capital) and SNF prospective payment systems, could provide us with the conceptual framework, we are not applying an update framework at this time.

In the March 22, 2002 proposed rule, we pointed out that it is important to develop successively more refined models of an update framework based on our evaluation of public comments and recommendations submitted to us on this issue. We would then further study the potential adjustments using the best available data. To actively pursue the development of an analytical framework that would support the continued appropriateness and relevance of the payment rates for services provided to beneficiaries in LTCHs, in the proposed rule, we requested comments concerning the use and feasibility of the conceptual approach outlined in section B of this Appendix. In the proposed rule, we specifically requested comments concerning which factors are appropriate and should be accounted for in the framework, and suggestions concerning potential data sources and analysis to support the model. As with the existing methodology used under the acute care hospital inpatient prospective payment system, the features of a LTCH-specific update framework would need to be based on sound policy and methodology. While we received no comments in response to this request, we continue to be interested in comments concerning the potential development of an update framework for the LTCH prospective payment system.

B. Factors Inherent in LTCH Payments Per Discharge

In order to understand the factors that determine LTCH costs per discharge, it is first necessary to understand the factors that determine LTCH payments per discharge. Payments per discharge under the LTCH prospective payment system are based on the cost and an implicit normal profit margin to the LTCH in providing an efficient level of care. We have developed a methodology to identify a mutually exclusive and exhaustive set of factors included in LTCH payments per discharge. The discussion here details a set of equations to identify these factors.

In its simplest form, the average payment per discharge to a LTCH can be separated into a cost term and a profit term as shown in equation (1):

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} + \frac{\text{Profits}}{\text{Discharge}} \quad (1)$$

This equation can be made multiplicative by converting profit per discharge into a profit rate as shown in equation (2):

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} * \frac{\text{Payments}}{\text{Costs}} \quad (2)$$

An output price term can be introduced into the equation by multiplying and dividing through by input prices and productivity. As shown in equation (3), the term inside the brackets represents the output price, since an output price reflects the input price and profit margin adjusted for productivity:

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}} \quad (3)$$

The cost per discharge term can be further separated by accounting for real case-mix. Under the LTCH prospective payment system, LTC–DRGs are used to classify patients. Based on accurate DRG classification data, average real case-mix per discharge can be incorporated, as shown in equation (4):

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs/Discharge}}{\text{Real Case Mix/Discharge}} * \frac{\text{Real Case Mix}}{\text{Discharge}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}} \quad (4)$$

The term ''real'' is imperative here because only true case-mix should be measured, not case-mix caused by improper coding behavior. By rearranging the terms in equation (4), a set of mutually exclusive and exhaustive factors such as those shown in equation (5) can be identified:

$$\frac{\text{Payments}}{\text{Discharge}} = \left(\frac{\frac{\text{Costs}}{\text{Discharge}}}{\text{Input Prices} * \frac{\text{Real Case Mix}}{\text{Discharge}}} * \text{Productivity} \right) * \frac{\text{Real Case Mix}}{\text{Discharge}} * \frac{1}{\text{Productivity}} * \text{Input Prices} * \frac{\text{Payments}}{\text{Costs}} \quad (5)$$

The term in brackets can be analyzed in two steps. First, excluding the productivity term results in case-mix adjusted real cost per discharge, which is input intensity per discharge. Second, multiplying input intensity by productivity results in case-mix adjusted real payment per discharge, or output intensity per discharge. The rationale behind this step is explained in detail in section C below.

The result of this exercise is that LTCH payment per discharge can be determined from the following factors:

$$\text{Payment Per Discharge} = \frac{\left(\begin{matrix} \text{Case-Mix-Constant} \\ \text{Real Output Intensity} \\ \text{Per Discharge} \end{matrix} \right) * \left(\begin{matrix} \text{Real Case Mix} \\ \text{per Discharge} \end{matrix} \right) * (\text{Input Prices}) * (\text{Profit Margins})}{\text{Productivity}} \quad (6)$$

Thus, it holds that the change in LTCH payment per discharge is a function of the change in these factors shown above. In order to determine an annual update that most accurately reflects the underlying cost to the LTCH of efficiently providing care, the four factors related to cost must be accounted for when an update framework is developed. A brief discussion of each factor, including specific conceptual and data issues, is provided in section C below.

C. Defining Each Factor Inherent in LTCH Costs Per Discharge

Each cost factor from equation (6) in section B is discussed here in detail. Because this is a basic conceptual discussion, it is likely that more detailed issues may be relevant that are not explored here.

1. Input Prices

Input prices are the pure prices of inputs used by the LTCH in providing services. When we refer to inputs, we are referring to costs, which have both a price and a quantity component. The price is an input price, and the quantity component reflects real inputs or real costs. Similarly, when we refer to outputs, we are referring to payments, which also have both a price and a quantity component. The price component is the transaction output price, and the quantity component is the real output or real payment. The real inputs include labor, capital, and other materials, such as drugs. By definition, an input price reflects prices that LTCHs encounter in purchasing these inputs, whereas an output price reflects the prices that buyers encounter in purchasing LTCH services. We currently measure input prices using the excluded hospital with capital market basket. While not specific to LTCHs, we believe this index adequately reflects the input prices faced by LTCHs.

2. Productivity

Productivity measures the efficiency of the LTCH in producing outputs. It is the amount of real outputs, or real payments, that can be produced from a given amount of real inputs or real costs. For LTCHs, these inputs are in the form of both labor and capital; thus, they represent multifactor productivity, as not just labor productivity is reflected. The following set of equations shows how multifactor productivity can be measured in terms of available data, such as payments, costs, and input prices:

$$\text{Productivity} = \frac{\text{Real Payments}}{\text{Real Costs}} = \frac{(\text{Payments}/\text{Output Price})}{(\text{Costs}/\text{Input Price})} = \frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Price}}{\text{Output Price}}$$

Rearranging the terms, this multifactor productivity equation was used as the basis for incorporating an output price term in equation (3) above. This equation is the basis for understanding the relationship between input prices, output prices, profit margins, and productivity.

Equation (6) shows that productivity is divided through the equation, offsetting other factors. The theory behind this offset is that if an efficient LTCH in a competitive market can produce more output with the same amount of inputs, the full increase in input costs does not have to be passed on by the provider to maintain a normal profit margin.

3. Real Case Mix Per Discharge

Real case mix per discharge is the average overall mix of care provided by the LTCH, as measured using the LTC–DRG classification system. Over time, a measure of real case mix will change as care is given in more or less complex LTC–DRGs. Changes in the level of care within a LTC–DRG classification group would not be reflected in a case-mix measure based on LTC–DRGs, but instead should be captured in the intensity factor of equation (6). The important distinction here is the difference between real and nominal case mix. Under the LTCH prospective payment system, LTCHs will submit claims using the LTC–DRG classification system. The case-mix reflected by the claims is considered ''nominal''. However, the reported classification can reflect the true level of care provided or improper coding behavior. An example of improper coding behavior would be the upcoding, or case-mix ''creep,'' that took place when the acute care hospital inpatient prospective payment system was implemented. (For further details, see ProPAC's March 1, 1994 Report and Recommendations to Congress (pp. 73–74).) Any change in case-mix that is not associated with the actual level of care or a true change in the level of care provided must be excluded in order to determine real case-mix.

4. Case-Mix Constant Real Output Intensity Per Discharge

Intensity is the true underlying nature of the product or service and can take the form of output or input intensity, or both. In the case of LTCHs, output intensity per discharge is associated with real payment per discharge, while input intensity per discharge is associated with real cost per discharge. For example, input intensity would be associated with a nurse's hours when providing treatment, whereas output intensity would be associated with the type and number of treatments a nurse provides. The underlying nature of LTCH services is determined by such factors as technological capabilities, increased utilization of inputs (such as labor or drugs), site of care, and practice patterns. Because these factors can be difficult to measure, intensity per discharge is usually calculated as a residual after the other factors from equation (6) have been accounted for.

Accounting for output intensity associated with an efficient LTCH can be more accurately analyzed using a LTCH's costs rather than its payments. This analysis would also provide an alternative to developing or using a transaction output price index. The following series of equations shows how to use the definition of an output price as defined earlier to convert the equation for output intensity per discharge to reflect costs instead of payments, as used in equation (6):

$$\text{Case-Mix-Constant Real Output Intensity per Discharge}$$

$$= \frac{[\text{Payments/Discharge}]}{\text{Output Prices} * \text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Payments/Discharge}]}{\left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}}\right) * \text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Payments/Discharge}] * \text{Costs}}{\text{Payments} * \frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Discharge}}$$

$$= \frac{\text{Payments} * [\text{Costs/Discharge}]}{\text{Payments} * \frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Costs/Discharge}]}{\frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Costs/Discharge}]}{\text{Input Prices} * \text{Real Case Mix/Discharge}} * \text{Productivity}$$

The last equation is identical to the term in brackets in equation (5), case-mix constant real input intensity per discharge multiplied by productivity. Thus, output intensity per discharge can be defined in such a way that cost data from the LTCH are utilized. This equation can be broken down even further to account for different types of input intensity per discharge. We discuss this matter more fully in section D below.

D. Applying the Factors that Affect LTCH Costs Per Discharge in an Update Framework

As discussed earlier, payments per discharge under the LTCH prospective payment system must be updated each year. Under this final rule, updates will be equal to the percent change in the excluded hospital with capital market basket beginning in FY 2004. The development of an update framework with a sound conceptual basis provides the capability to understand the underlying trends in LTCH costs per discharge for an efficient provider.

Earlier, factors inherent in LTCH costs per discharge were identified. Changes in these factors determine the change in LTCH costs per discharge and fitting these factors into an appropriate framework would allow us to accurately reflect changes in the underlying costs for efficient LTCHs. Accounting for each of these factors from equation (6) under the LTCH prospective payment system is discussed below:

- Change in case-mix constant real output intensity per discharge would be accounted for in the update framework, reflecting the factors that affect not only case-mix constant real input intensity per discharge, but also productivity, which is determined separately. Factors that can cause changes in case-mix constant real input intensity per discharge include, but are not limited to, changes in site of service, changes in within-LTC–DRG case-mix, changes in practice patterns, changes in the use of inputs, and changes in technology available.
- As discussed earlier, changes in nominal case-mix are automatically included in the payment to the LTCH. Therefore, the update framework should include an adjustment to convert changes in nominal case-mix per discharge to changes in real case-mix per discharge, if they are different.
- Change in multifactor productivity would be accounted for in the update framework. The availability of historical data on input prices, payments, and costs are useful in the analysis of this factor.
- Changes in input prices for labor, material, and capital would be accounted for in the update framework using an input price index, or market basket. To assist in updating payments for LTCH services, our Office of the Actuary currently has developed such an index; this is the excluded hospital with capital market basket.
- In an update framework, a forecast error adjustment would be included to reflect that the updates are set prospectively and a forecast error for a given year should not be perpetuated in payments for future years. In the case of the acute care hospital inpatient prospective payment system, this prospective adjustment is made on a 2-year lag and only if the error exceeds a defined threshold (0.25 percentage points).

E. Current Acute Care Hospital Inpatient Prospective Payment System and Illustrative LTCH Prospective Payment System Update Frameworks

Table I below shows the payment update framework for the current acute care hospital inpatient prospective payment system and an illustrative update framework for the LTCH prospective payment system. Some of the factors in the acute care hospital inpatient prospective payment system framework are computed using Medicare cost report data, while others are determined based on policy considerations. The details of calculating each factor for the acute care hospital inpatient prospective payment system framework can be found in the May 9, 2002 proposed rule (67 FR 31686) that set forth proposed updates to the payment rates used under the acute care hospital inpatient prospective payment system for FY 2003. This design for a LTCH update framework is for illustrative purposes only, as much more work needs to be done to determine the appropriate level of detail for each factor. The numbers provided for the hospital update are only intended to serve as examples of prior updates recommended for the acute care hospital inpatient prospective payment system.

The appropriateness of this framework for updating inpatient hospital payments was discussed in the Health Care Financing Review, Winter 1992, in an article entitled, ''Are PPS Payments Adequate? Issues for Updating and Assessing Rates.'' A similar framework would be useful for analyzing updates to LTCH payments.

TABLE I.—CURRENT CMS ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM AND ILLUSTRATIVE LTCH PROSPECTIVE PAYMENT SYSTEM UPDATE FRAMEWORKS

CMS Hospital Inpatient Prospective Payment System Update (Percent change in)	FY 2003 Calculated Hospital Update (Percent change)	Illustrative LTCH Prospective Payment System Update (Percent change in)
CMS Prospective Payment System Hospital Market Basket..	3.5	CMS Excluded Hospital with Capital Market Basket.
Forecast Error	0.7	Forecast Error.
Productivity	−0.9 to −0.7	Productivity.
Output Intensity:	1.0	Output Intensity:
Science and Technology		Science and Technology.
Practice Patterns		Real Within-DRG Change.
Real Within-DRG Change		Utilization of Inputs.
Site of Service		Site of Service.
Case-mix Adjustment Factors:		Case-mix. Adjustment Factors:
Projected Case-Mix	1.0	Nominal Across-DRG Case-Mix.
Real Across-DRG Change	−1.0	Real Across-DRG Change.
Total Cost Per Discharge	4.3 to 4.5	Total Cost Per Discharge.
Other Policy Factors:		Other Policy Factors:
Reclassification and Recalibration	−0.3	None.
Total Calculated Update	4.0 to 4.2	Total Calculated Update.

Table data derived from the May 9, 2002 Federal Register, Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2003 Rates; Proposed Rule (67 FR 31686–31688).

F. Additional Conceptual and Data Issues

Additional conceptual issues specific to the LTCH prospective payment system include the relevance of a site-of-service substitution adjustment, the necessity of an adjustment for LTC–DRG reclassification, the handling of one-time factors, and consistency with other types of hospital updates since LTCHs are similar in structure to these other types of hospitals.

Under the acute care hospital inpatient prospective payment system, a site-of-service substitution factor (captured as part of intensity) was necessary because of the incentive to shift care from inpatient hospital to other settings such as hospital outpatient departments, SNFs, or HHAs. For the LTCH prospective payment system, it is not clear without additional research whether there is an incentive to shift care either into or out of the LTCH because of the changes in behavior created by the different Medicare payment systems.

A reclassification and recalibration adjustment under the acute care hospital inpatient prospective payment system is necessary to account for changes in the case-mix or the types of patients treated by hospitals resulting from the annual reclassification and recalibration of the DRGs. This adjustment for case-mix is applied to the current fiscal year update, but reflects the effect of revisions in the fiscal year that is 2 years before that fiscal year. Whether a LTC–DRG reclassification adjustment would be necessary in the update framework would depend on the data availability and the likelihood of revisions to LTC–DRG classifications on a periodic basis.

There is also a question about how to handle one-time factors (an example of these could be those increased costs of converting computer systems to Year 2000 compliance). An update framework might be an appropriate mechanism to account for these items, but because of uncertainty surrounding their impact on costs, determining an appropriate adjustment amount may be difficult.

LTCHs are heterogeneous and are designated as a separate payment category only because their patients have longer average lengths of stay. This raises the question of whether certain factors in an update framework for LTCHs should be consistent with the factors in an update framework for other types of hospitals since they face similar cost pressures. Additional research in this area would need to be conducted to determine the reasonableness of having consistent updates.

The purpose of this conceptual discussion is not to determine how the identified factors of the update framework would be measured. We recognize that there are significant measurement issues in accurately determining the factors that would account for growth in costs per discharge for efficiently providing care. This is driven, in part, by the shift from a cost-based payment system with an upper payment limit to a prospective payment system. Significant research and data collection will be necessary to accurately measure these factors over the historical period. One example of this would be to measure the distinction between real and nominal case-mix change. However, many of these same concerns were also encountered and successfully addressed in the hospital inpatient prospective payment system update framework.

The discussion here provides the conceptual basis for developing an update framework for the LTCH prospective payment system that reflects changes in the underlying costs of efficiently providing services. It is important to note that the framework would not handle distribution issues such as geographic wage variations. Due to some variations in technical methodologies for measuring the factors of an update framework, and because of some of the data concerns mentioned earlier, implementing an update framework for the LTCH prospective payment system would involve making significant policy decisions on issues similar to those made for the hospital inpatient prospective payment system update framework.

In the March 22, 2002 proposed rule, we invited comments on the type of data sources to use, what other factors (if any) we should consider in an update framework, and any additional comments concerning the issues discussed in the proposed rule regarding the update framework. We receive no comments in response to this request. However, we continue to be interested in any comments regarding the development of an update framework for the LTCH prospective payment system.

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