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.