

information from LTCH patient records to classify patients into distinct long-term care diagnosis-related groups (LTC-DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each LTC-DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

The LTCH PPS replaced the reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248, for payments for inpatient services provided by a LTCH with a cost reporting period beginning on or after October 1, 2002. (The regulations implementing the TEFRA hospital payment provisions are located at 42 CFR part 413.) With the implementation of the prospective payment system for inpatient acute care hospitals authorized by the Social Security Amendments of 1983 (Pub. L. 98-21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and paid their reasonable costs for inpatient services subject to a per discharge limitation or target amount under the TEFRA system. For each cost reporting period, a ceiling on payments to each hospital excluded from the acute care hospital inpatient prospective payment system (IPPS) was determined by multiplying the hospital's updated target amount by the number of total current year Medicare discharges. The August 30, 2002 final rule further details payment policy under the TEFRA system (67 FR 55954).

In the August 30, 2002 final rule, we presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the budget neutrality requirements mandated by section 123 of Pub. L. 106-113. That same final rule, which established regulations for the LTCH PPS under 42 CFR part 412, Subpart O, also contained provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements.

We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS.

#### *B. Criteria for Classification as a LTCH*

LTCHs must have a provider agreement with Medicare and must have

an average Medicare inpatient length of stay of greater than 25 days, or, for cost reporting periods beginning on or after August 5, 1997, for a hospital that was first excluded from the PPS in 1986, must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principle diagnosis that reflects a finding of neoplastic disease. Subject to the provisions of § 412.23(e)(3), the average Medicare inpatient length of stay is determined based on all covered and noncovered days of stay of Medicare patients as calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period. Fiscal intermediaries verify that LTCHs meet the average length of stay requirements.

The fiscal intermediary's determination of whether or not a hospital qualifies as an LTCH is based on the hospital's discharge data from its most recent cost reporting period and is effective at the start of the hospital's next cost reporting period, under § 412.22(d). If a hospital does not meet the length of stay requirement, the hospital may provide the intermediary with data indicating a change in the hospital's average length of stay by the same method for the immediately preceding 6-month period (§ 412.23(e)(3)(ii)). (For procedural efficiency and in order to comply with the timing requirement of § 412.22(d), we have a longstanding policy of allowing hospitals to submit data for a period greater than 5 months for this purpose.) Requirements for hospitals seeking classification as LTCHs that have undergone a change in ownership, as described in § 489.18, are set forth in § 412.23(e)(3)(iii).

LTCHs that exist as hospitals-within-hospitals or satellite facilities must also meet the criteria set forth in § 412.22(e) or § 412.22(h), respectively, to be excluded from the IPPS and paid under the LTCH PPS.

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

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.
- Hospitals that are reimbursed in accordance with demonstration projects

authorized under section 402(a) of Pub. L. 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Pub. L. 92-603 (42 U.S.C. 1395b-1 (note)) (statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).

- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

#### *C. Transition Period for Implementation of the LTCH PPS*

In the August 30, 2002 final rule (67 FR 56038), we provided for a 5-year transition period from cost-based reimbursement to fully Federal prospective payment for LTCHs. During the 5-year period, two payment percentages are to be used to determine a LTCH's total payment under the PPS. The blend percentages are as follows:

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

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

#### *D. Limitation on Charges to Beneficiaries*

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH prospective payment system (67 FR 55974-55975). Under § 412.507, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under §§ 409.82, 409.83, and 409.87 and for items and services as specified under § 489.30(a), if the Medicare payment to the LTCH is the full LTC-DRG payment amount. However, if the Medicare payment was for a short-stay outlier case (§ 412.529) that was less than the full LTC-DRG payment amount, the LTCH could also charge the beneficiary for services for which the costs of those services or the days those services were provided were not a basis for calculating the Medicare short-stay outlier payment (§ 412.507).

Since the origin of the Medicare system, the intent of our regulations has been to set limits on beneficiary liability and to clearly establish the circumstances under which the