

patients who would have been classified to those DRGs were treated in LTCHs during FY 2001 and, therefore, no charge data were reported for those DRGs. Thus, in the process of determining the relative weights of LTC-DRGs, we were unable to determine weights for these 159 LTC-DRGs using the method described above. However, since patients with a number of the diagnoses under these LTC-DRGs may be treated at LTCHs beginning in FY 2003, we assigned relative weights to each of the 159 "no volume" LTC-DRGs based on clinical similarity and relative costliness to one of the remaining 351 ($510 - 159 = 351$) LTC-DRGs for which we were able to determine relative weights, based on the FY 2001 claims data. (A list of the no volume LTC-DRGs and further explanation of their relative weight assignment can be found in the August 30, 2002 final rule (67 FR 55991–55994).)

Furthermore, we establish LTC-DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC-DRGs 103, 302, 480, 495, 512 and 513, respectively) because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. If in the future, however, a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to propose appropriate weights for the LTC-DRGs effected. At the present time, though, we only include these six transplant LTC-DRGs in the GROUPER program for administrative purposes because since the LTCH PPS uses the same GROUPER program for LTCHs as is used under the IPPS, removing these DRGs would be administratively burdensome.

As we stated previously, we are proposing that we would continue to use the same LTC-DRGs and relative weights until October 1, 2003. Accordingly, Table 3 in the Addendum to this proposed rule lists the LTC-DRGs and their respective relative weights and arithmetic mean length of stay that we are proposing would continue to be used for the period of July 1, 2003 through September 30, 2003. (This table is the same as Table 3 of the Addendum to the August 30, 2002 final rule (67 FR 56076–56084), except that it includes the proposed five-sixth of the average length of stay for short-stay outliers under § 412.529. As we noted in section IV.D. of this

preamble, we are proposing that the final DRGs and GROUPER for FY 2004 that would be used for the IPPS and the LTCH PPS, effective October 1, 2003, would be presented in the IPPS FY 2004 final rule published no later than August 1, 2003 in the **Federal Register**.

Accordingly, we would notify LTCHs of the revised LTC-DRG relative weights for use in determining payments for discharges occurring between October 1, 2003 and September 30, 2004, based on the final DRGs and Version 21.0 GROUPER published in the IPPS rule on or before August 1, 2003.

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

In the March 22, 2002 proposed rule related to the establishment of the LTCH PPS (67 FR 13416), we stated that we were considering proposing the elimination of the bed limit in § 412.22(h)(2)(i) for pre-1997 excluded hospitals once the applicable prospective payment system was fully phased in and all payments were based on 100 percent of the Federal prospective payment rates. This statement generated a number of comments and in the August 30, 2002 final rule (67 FR 56012), we stated our agreement with commenters who urged us to adopt a policy eliminating the bed-number restrictions for pre-1997 LTCHs with satellite facilities, as soon as a LTCH elected to be paid based on 100 percent of the Federal prospective rate. However, we also noted that we would address a change in the policy concerning bed limits in the next update of the LTCH PPS. Therefore, we are now proposing to eliminate the application of the bed-number restrictions set forth in § 412.22(h)(i) for LTCHs established prior to 1997 with satellite facilities, effective at the start of the first cost reporting year that the LTCH is paid under the 100 percent fully Federal prospective payment system. This would be either when the LTCH elects to be paid based on 100 percent of the Federal prospective rate or when the LTCH is transitioned to 100 percent of the Federal prospective rate, whichever comes first.

Presently, section 1886(b)(3) of the Act, as amended by section 4414 of Pub. L. 105–33, requires existing LTCHs to be subject to caps on their target amounts for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. For purposes of calculating these caps, the statute required the Secretary to "estimate the 75th percentile of the target amounts for such hospitals within [each] class for cost reporting periods ending during

fiscal year 1996." Section 1886(b)(3)(H) of the Act, as amended by section 121 of Pub. L. 106–113, directed the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric and rehabilitation hospitals and units and LTCHs effective for cost reporting periods beginning on or after October 1, 1999 through September 30, 2002. In addition, payment limits were established for new excluded hospitals or units (excluding children's hospitals) effective October 1, 1997. For new excluded hospitals (that is, post-1997 LTCHs), section 1886(b)(7) of the Act, as added by section 4416 of Pub. L. 105–33, specified that the payment amount for the facility's first two 12-month cost reporting periods, for which the hospital has a settled cost report, must not exceed 110 percent of the national median of target amounts of similarly classified hospitals for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the first cost reporting period in which the hospital receives payment, as adjusted by section 1886(b)(7)(C) of the Act. The result of section 4414 and 4416 of Pub. L. 105–33 was a distinction between the LTCHs established prior to and those established after 1997 with lower payment caps for the post-1997 LTCHs.

In the July 30, 1999 final rule for the IPPS (64 FR 41532–41533), we promulgated regulations at § 412.22(h)(2)(i) to discourage pre-1997 excluded hospitals, which had the higher caps on target amounts as discussed above (under § 413.40(c)(4)(iii), which implemented section 4414 of Pub. L. 105–33), from creating satellite arrangements rather than establishing new hospitals, in order to avoid the payment impact of the lower caps that apply to new hospitals (under § 413.40(f)(2)(ii) which implemented section 4416 of Pub. L. 105–33). Under the July 30, 1999 acute care hospital inpatient final rule (64 FR 41490), in order to address this possibility of gaming if a pre-1997 excluded hospital, such as a LTCH, established a satellite facility and, in doing so, its total beds, in both the parent hospital (or unit) and the satellite facility, exceeded the number of State-licensed and Medicare-certified beds in the parent hospital on the last day of its last cost reporting period beginning before October 1, 1997, the excluded hospital would be paid under the inpatient DRG system instead of receiving payment as an excluded hospital under the TEFRA payment system. Although the excluded hospital