

percent of projected total LTCH PPS payments.

Outlier payments under the LTCH PPS are determined consistent with the IPPS outlier policy. Currently, under the IPPS, a floor and a ceiling are applied to an acute care hospital's cost-to-charge ratio and if the acute care hospital's cost-to-charge ratio is either below the floor or above the ceiling, the applicable statewide average cost-to-charge ratio is assigned to the acute care hospital. Similarly, if a LTCH's cost-to-charge ratio is below the floor or above the ceiling, currently the applicable statewide average cost-to-charge ratio is assigned to the hospital. In addition, for LTCHs for which we are unable to compute a cost-to-charge ratio, we also assign the applicable statewide average. Currently, MedPAR claims data and cost-to-charge ratios based on the latest available cost report data from HCRIS and corresponding MedPAR claims data are used to establish a fixed-loss threshold amount under the LTCH PPS.

For FY 2003, based on FY 2001 MedPAR claims data and cost-to-charge ratios based on the latest available data from HCRIS and corresponding MedPAR claims data from FYs 1998 and 1999, we established a fixed-loss amount of \$24,450. For the proposed 2004 LTCH PPS rate year, we are proposing to continue to use the March 2002 update of the FY 2001 MedPAR claims data to determine a fixed-loss threshold that would result in outlier payments being equal to 8 percent of total payments, based on the policies described in this proposed rule, because these data are the best data available. We would calculate cost-to-charge ratios for determining the proposed fixed-loss amount based on the latest available cost report data in HCRIS and corresponding MedPAR claims data from FYs 1998, 1999, and 2000. Consistent with the proposed outlier policy changes for acute care hospitals under the IPPS discussed in the March 4, 2003 proposed rule, we are proposing to no longer assign the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio falls below the floor. We are proposing this policy change because, as is the case for acute care hospitals, we believe LTCHs could arbitrarily increase their charges in order to maximize outlier payments. Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), currently when a LTCH's actual cost-to-charge ratio falls below the floor, the LTCH's cost-to-charge ratio would be raised to the applicable statewide average. This application of the statewide average

would result in inappropriately higher outlier payments. Accordingly, we are proposing to apply the LTCH's actual cost-to-charge ratio to determine the cost of the case, even where the LTCH's actual cost-to-charge ratio falls below the floor. No longer applying the applicable statewide average cost-to-charge ratio when a LTCH's actual cost-to-charge ratio falls below the floor would result in a lower future cost-to-charge ratio. Applying this lower cost-to-charge ratio to charges in the future to determine the cost of the case would result in more appropriate outlier payments. Therefore, consistent with the proposed policy change for acute care hospitals under the IPPS, we are proposing that LTCHs would receive their actual cost-to-charge ratios no matter how low their ratios fall. Also, consistent with the proposed policy change for acute care hospitals under the IPPS, we are proposing under § 412.525(a)(4), by cross-referencing proposed § 412.84(i), to continue to apply the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio exceeds the ceiling by adopting the proposed policy at proposed § 412.84(i)(1)(ii). Cost-to-charge ratios above this range are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because such data are clearly errors and should not be relied upon. In addition, we are proposing to make a similar change to § 412.529(c), by cross-referencing proposed § 412.84(i), for determining short-stay outlier payments to indicate that the applicable statewide average cost-to-charge ratio would be applied when a LTCH's cost-to-charge ratio exceeds the ceiling, but not when a LTCH's cost-to-charge ratio falls below the floor. Since cost-to-charge ratios are also used in determining short-stay outlier payments, the rationale for this proposed change mirrors that for high-cost outliers.

Therefore, consistent with IPPS outlier policy in determining the proposed fixed-loss amount for the proposed 2004 LTCH PPS rate year, we are proposing to use only the current combined operating and capital cost-to-charge ratio ceiling under the IPPS of 1.421 (as explained in the acute care hospital inpatient PPS final rule (67 FR 50125, August 1, 2002)). We believe that using the current combined IPPS operating and capital cost-to-charge ratio ceiling for LTCHs is appropriate since, as we explained in the August 30, 2002 final rule (67 FR 55960), LTCHs are certified as acute care hospitals that

meet the criteria set forth in section 1861(e) of the Act in order to participate in the hospital in the Medicare program. As we also discussed in the August 30, 2002 final rule (67 FR 55956), in general hospitals are paid as a LTCH only because their average length of stay is greater than 25 days in accordance with § 412.23(e). Furthermore, prior to qualifying as a LTCH under § 412.23(e)(2)(i), the hospitals generally are paid as acute care hospitals under the IPPS during the period in which they demonstrate that they have an average length of stay of greater than 25 days. Accordingly, if a LTCH's cost-to-charge ratio is above this ceiling, we are proposing to assign the applicable IPPS statewide average cost-to-charge ratio. (Currently, the applicable IPPS statewide averages can be found in Tables 8A and 8B of the August 1, 2002 IPPS final rule (67 FR 50263).) We would also assign the applicable statewide average for LTCHs for which we are unable to compute a cost-to-charge ratio. Accordingly, for the proposed 2004 LTCH PPS rate year, we are proposing a fixed-loss amount of \$19,978. Thus, we would pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC-DRG and the proposed fixed-loss amount of \$19,978).

As we discussed in section IV.D. of this preamble, the IPPS standard Federal rate and relative weights are updated simultaneously, effective October 1 of each year, when the new GROUPE with the final DRGs and the new relative weights are implemented for that fiscal year. The LTCH PPS utilizes the same DRGs and Medicare GROUPE program as the IPPS. The GROUPE in effect on July 1, 2003 will be version 20.0. Although we are proposing to update the LTCH PPS standard Federal rate on July 1, 2003, version 21.0 of the GROUPE will not be available at the time the final rule following this proposed rule is published. To the extent that the LTC-DRG weights in the version 21.0 GROUPE may change, total LTCH PPS payments may also change. Therefore, as explained in section IV.F. of this proposed rule, we are not proposing an update to the LTC-DRG weights for the period of July 1, 2003 through September 30, 2003, and the LTCH PPS would continue to use version 20.0 of the GROUPE and the LTC-DRG relative weights published in Table 3 of the Addendum to the August 30, 2002 final rule (reprinted in Table 3 of the Addendum to this proposed rule) for the