

4. Proposed Adjustments for Special Cases

a. General

As discussed in the August 30, 2002 final rule (67 FR 55995), under section 123 of Pub. L. 106–113 the Secretary generally has broad authority in developing the PPS for LTCHs, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs.

Generally, LTCHs, as described in section 1886(d)(1)(B)(iv) of the Act, are distinguished from other inpatient hospital settings by maintaining an average length of stay of greater than 25 days. However, LTCHs may have cases that have stays of considerably less than the average length of stay and that receive significantly less than the full course of treatment for a specific LTC–DRG. As we explained in the August 30, 2002 final rule (67 FR 55995), such cases would be paid inappropriately if the hospital were to receive the full LTC–DRG payment. While we are not proposing any changes to the payment policy for special cases at this time, below we discuss the payment methodology for these special cases as implemented in the August 30, 2002 final rule (67 FR 55955–56010).

b. Short-Stay Outlier Cases

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

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

Under § 412.529, we adjust the per discharge payment to the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC–DRG payment, for all cases with a

length of stay up to and including five-sixths of the geometric average length of stay of the LTC–DRG.

As we discussed above, in section VI.C.3. of this preamble, in the March 4, 2003 proposed rule we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because, as we discussed in that notice, we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because the LTCH PPS high-cost outlier and short-stay outlier policies are modeled after the outlier policy in the IPPS, we believe they are susceptible to the same payment vulnerabilities and, therefore, merit revision. As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) and (m) in the March 4, 2003 proposed rule and as we are proposing above for high-cost outlier payments at § 412.525(a)(4)(ii), we are proposing under § 412.529 that short-stay outlier payments would be subject to the proposed provisions in the regulations at § 412.84(i) and (m). Therefore, consistent with the proposed changes to the high-cost outlier policy discussed above in section VI.C.3. of this preamble, we are proposing, by cross-referencing § 412.84(i), that fiscal intermediaries would use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later, in determining a LTCH’s cost-to-charge ratio. We also are proposing, by cross-referencing § 412.84(i), that the applicable statewide average cost-to-charge ratio would be applied when a LTCH’s cost-to-charge ratio exceeds the ceiling. Finally, we are proposing, by cross-referencing § 412.84(m), that any reconciliation of payments for short-stay outliers would be made upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. As is the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we are still assessing the procedural changes that would be necessary to implement this change.

c. Interrupted Stay

In § 412.531(a), we define an “interruption of a stay” as a stay at a LTCH 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 LTCH and returns to the same LTCH within applicable fixed day periods. For a discharge to an acute care hospital, the applicable fixed-day period is 9 days. For a discharge to

an IRF, the applicable fixed-day period is 27 days. For a discharge to a SNF, the applicable fixed-day period is 45 days. The counting of the days begins on the day of discharge from the specified facility and ends on the 9th, 27th, or 45th day for an acute care hospital, an IRF, or a SNF, respectively. (We refer readers to section VI.C.4.e. of this preamble for a discussion of application of this interrupted stay policy to Medicare-participating providers with approved swing beds.)

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 only a single LTCH PPS payment will be made. (From the standpoint of implementing this policy, in the event that a Medicare inpatient is discharged from a LTCH and is readmitted and the stay qualifies as an interrupted stay, the provider should cancel the claim generated by the original stay in the LTCH and submit one claim for the entire stay. For further details, see Program Memorandum Transmittal A–02–093, September 2002.) On the other hand, if the patient stay exceeds the total fixed-day threshold outside of the LTCH at another facility before being readmitted, two separate LTC–DRG payments will be made, one based on the principal diagnosis for the first admittance and the other based on the principal diagnosis for the second admittance. Moreover, if the principal diagnoses are the same for both admissions, the hospital could receive two similar payments. (See section VI.C.4.e. of this proposed rule for application of the interrupted stay policy to transfers to swing bed hospitals.)

d. Onsite Discharges and Readmittances

Under § 412.532, 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 apply one threshold for discharges and readmittances with a co-located acute care hospital. There is also 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,