

those facilities that have received approval from CMS as transplant centers.)

- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the proposed DRG weights for FY 2004. Using the FY 2002 MedPAR data set, there are 42 DRGs that contain fewer than 10 cases. We computed the weights for these low-volume DRGs by adjusting the proposed FY 2003 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The proposed new weights are normalized by an adjustment factor (1.45510) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

As noted below in section IV.A.2., we are proposing to expand the transfer policy applicable to postacute care transfers from 10 DRGs currently to an additional 19 DRGs, beginning in FY 2004. Because we count a transfer case as a fraction of a case as described above in the recalibration process, any expansion of the postacute care transfer policy to 19 additional DRGs would affect the proposed relative weights for those DRGs. Therefore, we calculated the proposed FY 2004 normalization factor comparing the case-mix using the proposed FY 2004 DRG relative weights in which we treated postacute care transfer cases in the 19 DRGs proposed to be added to the postacute transfer policy for FY 2004 as a fraction of a case with the case-mix using the FY 2003 DRG relative weights without treating cases in these 19 additional DRGs as transfer cases.

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the

aggregate payments that would have been made without the changes.

Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.a. of the Addendum to this proposed rule, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

D. Proposed LTC-DRG Reclassifications and Relative Weights for LTCHs for FY 2004

1. Background

In the March 7, 2003 LTCH PPS proposed rule (68 FR 11234), we proposed to change the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, since the patient classification system utilized under the LTCH PPS is based directly on the DRGs used under the IPPS for acute care hospitals, in that same proposed rule, we proposed that the annual update of the long-term care diagnosis-related group (LTC-DRG) classifications and relative weights would continue to remain linked to the annual reclassification and recalibration of the CMS-DRGs under the IPPS.

The annual update to the IPPS DRGs is based on the annual revisions to the ICD-9-CM codes and is effective each October 1. In the health care industry, annual changes to the ICD-9-CM codes are effective for discharges occurring on or after October 1 each year. The use of the ICD-9-CM coding system is also compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104-191, under 45 CFR Parts 160 and 162. Therefore, the manual and electronic versions of the Grouper software, which are based on the ICD-9-CM codes, are also revised annually and effective for discharges occurring on or after October 1 each year. Because the LTC-DRGs are based on the patient classification system used under the IPPS (CMS-DRGs), which is updated annually and effective for discharges occurring on or after October 1 through September 30 each year, in the March 7, 2003 LTCH PPS proposed rule (68 FR 11234), we proposed to continue to update the LTC-DRG classifications and relative weights to be effective for

discharges occurring on or after October 1 through September 30 each year.

As we explained in the March 7, 2003 LTCH PPS proposed rule (68 FR 11234), the FY 2004 DRGs and relative weights used under the IPPS had not yet been proposed, and we were unable to propose updated LTC-DRGs and relative weights at that time. Therefore, since the LTC-DRG classifications and relative weights would continue to be based on the annual updates to the IPPS DRGs, we proposed that proposed revisions to the LTC-DRG classifications and relative weights would be presented for public comment in the IPPS proposed rule and finalized in the IPPS final rule, to be effective October 1, 2003 through September 30, 2004.

For FY 2003, version 20.0 of the DRG Grouper is being utilized under both the IPPS and the LTCH PPS. The LTC-DRG classifications and relative weights are shown in Table 3 of the Addendum to the August 30, 2002 for FY 2003 final rule (67 FR 56076-56084) and in Table 3 of the Addendum to the March 7, 2003 LTCH PPS proposed rule (68 FR 11285 through 11292). Below we discuss the proposed LTC-DRGs and relative weights for FY 2004 based on the proposed changes to the hospital IPPS DRGs (Grouper version 21.0) discussed in section II. of this preamble.

2. Proposed Changes in the LTC-DRG Classifications

a. Background. Section 123 of Pub. L. 106-113 specifically requires that the PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Pub. Law 106-554 modified the requirements of section 123 of Pub. L. 106-113 by specifically requiring that the Secretary examine "the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data."

In accordance with section 307(b)(1) of Pub. L. 106-554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC-DRGs based on clinical characteristics and expected resource needs. The LTC-DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs