

The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we adjust the LTCH PPS standard Federal prospective payment system rate by the LTC-DRG relative weights in determining payment to LTCHs for each case.

Under the LTCH PPS, relative weights for each LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each LTC-DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC-DRG that represents the resources needed by an average inpatient LTCH case in that LTC-DRG. For example, cases in a LTC-DRG with a relative weight of 2 will, on average, cost twice as much as cases in a LTC-DRG with a weight of 1.

b. Data. To calculate the proposed LTC-DRG relative weights for FY 2004 in this proposed rule, we obtained total Medicare allowable charges from FY 2002 Medicare hospital bill data from the December 2002 update of the MedPAR file, and we used the proposed Version 21.0 of the CMS GROUPER used under the acute care hospital inpatient IPPS as discussed above in section II.B. of this preamble. Consistent with the methodology under the hospital IPPS, we are proposing to recalculate the FY 2004 LTC-DRG relative weights based on the best available data for the final rule.

As we discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 55984), based on comments regarding the data used in the development of the LTCH prospective payment system, we have excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1). Therefore, in the development of the proposed FY 2004 LTC-DRG relative weights we have excluded the data of the 22 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects.

In addition, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55989), a data problem regarding the proposed FY 2003 LTC-DRG relative weight values that were

determined using MedPAR (claims) data for FYs 2000 and 2001 was brought to our attention. Following notification of this problem, we researched the commenter's claims and determined that, given the long stays at LTCHs, some providers had submitted multiple bills for payment under the TEFRA reimbursement system for the same stay. Based upon our research, we became aware of the following situation: In certain LTCHs, hospital personnel apparently reported a different principal diagnosis on each bill since, under the TEFRA system, payment was not dependent upon principal diagnosis as it is under a DRG-based system. These claims from the MedPAR file were run through the LTCH GROUPER and used in determining the proposed FY 2003 relative weights for each LTC-DRG.

Since this issue was brought to our attention and we discovered that only data from the final bills were being extracted for the MedPAR file, it was possible that the original MedPAR file was not receiving the correct principal diagnosis. Therefore, in the August 30, 2002 final rule (67 FR 55989), we addressed the problem by identifying all LTCH cases in the FY 2001 MedPAR file for which multiple bills were submitted. For each of these cases, beginning with the first bill and moving forward consecutively through subsequent bills for that stay, we recorded the first unique diagnosis codes up to 10 and the first unique procedure codes up to 10. We then used these codes to appropriately group each LTCH case to a LTC-DRG for FY 2003.

As we noted above, we are proposing to use LTCH claims data from the FY 2002 MedPAR file for the determination of the proposed FY 2004 LTC-DRG relative weights. Since at the time (FY 2002) LTCHs were still reimbursed under the TEFRA reasonable cost-based system, some LTCHs also had submitted multiple bills for Medicare payment for the same stay. Thus, in certain LTCHs, hospital personnel were apparently still reporting a different principal diagnosis on each bill since, under the TEFRA system in FY 2002, payment was not dependent upon principal diagnosis as it is under a DRG-based system. Therefore, we are proposing to follow the same methodology outlined above to determine the appropriate diagnosis and procedure codes for those multiple bill LTCH cases in the FY 2002 MedPAR files, and we are proposing to use these codes to group each LTCH case to a proposed LTC-DRG for FY 2004. Since the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003), we believe that this problem will be self-correcting

as LTCHs submit more completely coded data in the future.

c. Hospital-Specific Relative Value Methodology. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), by nature LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such nonarbitrary distribution of cases with relatively high (or low) charges in specific LTC-DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, as explained in that same final rule (67 FR 55985), we use a hospital-specific relative value method to calculate the proposed LTC-DRG relative weights instead of the methodology used to determine the proposed DRG relative weights under the hospital IPPS described above in section II.C. of this preamble. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC-DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the hospital-specific relative value method, as we explained in the August 30, 2002 LTCH PPS final rule (67 FR 55985), we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, averages 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55985), we standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.D.4. (step 3) of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated.