

Acronyms

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding terms in alphabetical order below:

BBA Balanced Budget Act of 1997, Public Law 105–33
 BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
 BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106–554
 CMS Centers for Medicare & Medicaid Services
 DRGs Diagnosis-related groups
 FY Federal fiscal year
 HCRIS Hospital Cost Report Information System
 HHA Home health agency
 HIPAA Health Insurance Portability and Accountability Act, Public Law 104–191
 IPPS Acute Care Hospital Inpatient Prospective Payment System
 IRF Inpatient rehabilitation facility
 LTC—DRG Long-term care diagnosis-related group
 LTCH Long-term care hospital
 MedPAC Medicare Payment Advisory Commission
 MedPAR Medicare provider analysis and review file
 OSCAR Online Survey Certification and Reporting (System)
 PPS Prospective Payment System
 QIO Quality Improvement Organization (formerly Peer Review organization (PRO))
 SNF Skilled nursing facility
 TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248

I. Background

A. Legislative and Regulatory Authority

The Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) provide for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare part A based on prospectively set rates. The Medicare prospective payment system for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002.

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as “a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.” Section 1886(d)(1)(B)(iv)(II) of the Act also provides an alternative definition of LTCHs: Specifically, a hospital that first

received payment under section 1886(d) of the Act in 1986 and has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in FY 1997.

Section 123 of Public Law 106–113 requires the prospective payment system for LTCHs to be a per discharge system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs while maintaining budget neutrality.

Section 307(b)(1) of Public Law 106–554, among other things, mandates that the Secretary shall examine and may provide for adjustments to payments under the LTCH PPS, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

In a **Federal Register** document issued on August 30, 2002 (67 FR 55954), we implemented the LTCH PPS authorized under Public Law 106–113 and Public Law 106–554. This system uses information from LTCH patient records to classify patients into distinct long-term care diagnosis-related groups (LTC—DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each LTC—DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

The LTCH PPS replaced the reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97–248, for payments for inpatient services provided by a LTCH with a cost reporting period beginning on or after October 1, 2002. (The regulations implementing the TEFRA (reasonable cost-based) payment provisions are located at 42 CFR part 413.) With the implementation of the prospective payment system for inpatient acute care hospitals authorized by the Social Security Amendments of 1983 (Public Law 98–21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and were paid their reasonable costs for inpatient services subject to a per discharge limitation or target amount under the TEFRA system. For each cost reporting period, a hospital-specific ceiling on payments was determined by multiplying the

hospital's updated target amount by the number of total current year Medicare discharges. The August 30, 2002, final rule further details payment policy under the TEFRA system (67 FR 55954).

In the August 30, 2002, final rule, we presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the budget neutrality requirements mandated by section 123 of Public Law 106–113. The same final rule, that established regulations for the LTCH PPS under 42 CFR part 412, subpart O, also contained provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements.

We refer readers to the August 30, 2002, final rule (67 FR 55954) for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS.

B. Criteria for Classification as a LTCH

LTCHs must have a provider agreement with Medicare and (1) must have an average Medicare inpatient length of stay of greater than 25 days, or (2), for a hospital that was first excluded from the PPS in 1986, must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principle diagnosis that reflects a finding of neoplastic disease. Subject to the provisions of § 412.23(e)(3), for the first type of LTCHs as noted above, the average Medicare inpatient length of stay is determined based on all covered and noncovered days of stay of Medicare patients as calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period. Fiscal intermediaries verify that LTCHs meet the average length of stay requirements. We note that the inpatient days of a patient who is admitted to a LTCH without any remaining Medicare days of coverage, regardless of the fact that the patient is a Medicare beneficiary, will not be included in the above calculation. Because Medicare would not be paying for any of the patient's treatment, data on the patient's stay would not be included in our systems. In order for noncovered days of a LTCH