

hospitalization to be included, a patient must have at least one remaining benefit day as described in § 409.61.

The fiscal intermediary's determination of whether or not a hospital qualifies as an LTCH is based on the hospital's discharge data from its most recent cost reporting period and is effective at the start of the hospital's next cost reporting period, as set forth under § 412.22(d). If a hospital does not meet the length of stay requirement, the hospital may provide the intermediary with data indicating a change in the hospital's average length of stay by the same method for the immediately preceding 6-month period (§ 412.23(e)(3)(ii)). (For procedural efficiency and in order to comply with the timing requirement of § 412.22(d), we have a longstanding policy of allowing hospitals to submit data for a

period greater than 5-months for this purpose.) Requirements for hospitals seeking classification as LTCHs that have undergone a change in ownership, as described in § 489.18, are set forth in § 412.23(e)(3)(iii).

LTCHs that exist as hospitals-within-hospitals or satellite facilities must also meet the criteria set forth in § 412.22(e) or § 412.22(h), respectively, to be excluded from the IPPS and paid under the LTCH PPS.

The following hospitals are paid under special payment provisions, as described in § 412.22(c) and, therefore, are not subject to the LTCH PPS rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403.
- Hospitals 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 (note)) (statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).

- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

C. *Transition Period for Implementation of the LTCH PPS*

In the August 30, 2002, final rule, we provided for a 5-year transition period from cost-based reimbursement to fully Federal prospective payment for LTCHs (67 FR 56038). During the 5-year period, two payment percentages are to be used to determine a LTCH's total payment under the PPS. The blend percentages are as follows:

Cost reporting periods beginning on or after	Prospective payment Federal rate percentage	Cost-based reimbursement rate percentage
October 1, 2002 .....	20	80
October 1, 2003 .....	40	60
October 1, 2004 .....	60	40
October 1, 2005 .....	80	20
October 1, 2006 .....	100	0

D. *Limitation on Charges to Beneficiaries*

In the August 30, 2002, final rule, we presented an in-depth discussion of beneficiary liability under the LTCH prospective payment system (67 FR 55974-55975). Under § 412.507, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under §§ 409.82, 409.83, and 409.87 and for items and services as specified under § 489.30(a), if the Medicare payment to the LTCH is the full LTC-DRG payment amount. However, if the Medicare payment was for a short-stay outlier case (§ 412.529) that was less than the full LTC-DRG payment amount, the LTCH could also charge the beneficiary for services for which the costs of those services or the days those services were provided were not a basis for calculating the Medicare short-stay outlier payment (§ 412.507).

Since the origin of the Medicare system, the intent of our regulations has been to set limits on beneficiary liability and to clearly establish the circumstances under which the beneficiary would be required to assume responsibility for payment; that is, upon exhausting benefits described in 42 CFR

part 409, subpart F. The discussion in the August 30, 2002, final rule was not meant to establish rates or payments for, or define, Medicare-eligible expenses. While we regulate beneficiary liability for coinsurance and deductibles for hospital stays that are covered by Medicare, payments from Medigap insurers to providers for inpatient hospital coverage after Medicare benefits are exhausted are not regulated by us. Furthermore, regulations beginning at § 403.200 and the 1991 National Association of Insurance Commissioners (NAIC) Model Regulation for Medicare Supplemental Insurance, which was incorporated by reference into section 1882 of the Act, govern the relationship between Medigap insurers and beneficiaries.

E. *System Implementation for the LTCH PPS*

When we established the regulations to implement the LTCH PPS on August 30, 2002 (67 FR 55954), effective for cost reporting periods that began on or after October 1, 2002, we did not have computer system changes in place that were necessary to accommodate claims processing and payment under the system. However, after January 1, 2003, we made the necessary system changes. Accordingly, after January 1, 2003, the

fiscal intermediary has been required to reconcile the payment amounts that had been made to LTCHs for all covered inpatient hospital services furnished to Medicare beneficiaries from cost reporting periods that began on or after October 1, 2002, through January 1, 2003, with the amounts that were payable under the LTCH PPS methodology. Because the LTCH PPS was effective at the start of the LTCH's first cost reporting period that began on or after October 1, 2002, only those LTCHs with cost reporting periods that started October 1, 2002, through January 1, 2003, will experience the payment reconciliation necessitated by this 3-month period prior to systems implementation. The claims submission procedure of using ICD-9-CM codes has not changed following the systems implementation of the LTCH PPS.

We also want to note that as of October 16, 2002, a LTCH that was required to comply with the Administrative Simplification Standards under the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104-191) and that had not obtained an extension in compliance with the Administrative Compliance Act (Pub. L. 107-105) is obligated to comply with the standards for submitting claim forms to the