

charges in the calculation of the LTC-DRG relative weights.

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 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, we use a hospital-specific relative value method to calculate relative weights. We believe this method removes this hospital-specific source of bias in measuring 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. (See the August 30, 2002, final rule (67 FR 55985) for further information of the hospital-specific relative value methodology.)

In order to account for LTC-DRGs with low volume (that is, with fewer than 25 LTCH cases), we grouped those low volume LTC-DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For FY 2003 based on the FY 2001 MedPAR data, we identified 161 LTC-DRGs that contained between 1 and 24 cases. This list of low volume LTC-DRGs was then divided into one of the five low volume quintiles, each containing a minimum of 32 LTC-DRGs ($161/5 = 32$ with 1 LTC-DRG as a remainder). Each of the low volume LTC-DRGs grouped to a specific quintile received the same relative weight and average length of stay using the formula applied to the regular LTC-DRGs (25 or more cases), as described below. (See the August 30, 2002, final rule (67 FR 55985–55988) for further explanation of the development and composition of each of the five low volume quintiles for FY 2003.)

After grouping the cases in the appropriate LTC-DRG, we calculate the relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we adjust the number of cases in each LTC-DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges were used to calculate "relative adjusted weights" in each LTC-DRG using the hospital-specific relative value method described above. (See the August 30, 2002, final rule (67 FR

55989–55995) for further details on the steps for calculating the LTC-DRG relative weights.)

We also adjust the LTC-DRG relative weights to account for nonmonotonically increasing relative weights. That is, we make an adjustment if cases classified to the LTC-DRG "with comorbidities (CCs)" of a "with CC"/"without CC" pair had a lower average charge than the corresponding LTC-DRG "without CCs" by assigning the same weight to both LTC-DRGs in the "with CC"/"without CC" pair. (See August 30, 2002, 67 FR 55990–55991). In addition, of the 510 LTC-DRGs in the LTCH PPS for FY 2003, based on the FY 2001 MedPAR data, we identified 159 LTC-DRGs for which there were no LTCH cases in the database. That is, no patients who would have been classified to those DRGs were treated in LTCHs during FY 2001 and, therefore, no charge data were reported for those DRGs. Thus, in the process of determining the relative weights of LTC-DRGs, we were unable to determine weights for these 159 LTC-DRGs using the method described above. However, since patients with a number of the diagnoses under these LTC-DRGs may be treated at LTCHs beginning in FY 2003, we assigned relative weights to each of the 159 "no volume" LTC-DRGs based on clinical similarity and relative costliness to one of the remaining 351 ($510 - 159 = 351$) LTC-DRGs for which we were able to determine relative weights, based on the FY 2001 claims data. (A list of the no volume LTC-DRGs and further explanation of their relative weight assignment can be found in the August 30, 2002, final rule (67 FR 55991–55994).)

Furthermore, we establish LTC-DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC-DRGs 103, 302, 480, 495, 512 and 513, respectively) because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. If in the future, however, a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to propose appropriate weights for the LTC-DRGs effected. At the present time, though, we only include these six transplant LTC-DRGs in the GROUPER program for administrative purposes because since the LTCH PPS uses the same GROUPER program for LTCHs as is used under the IPPS,

removing these DRGs would be administratively burdensome.

As we stated in the March 7, 2003, proposed rule, we proposed that we would continue to use the same LTC-DRGs and relative weights until October 1, 2003. Accordingly, Table 3 in the Addendum to the March 7, 2003, proposed rule lists the LTC-DRGs and their respective relative weights and arithmetic mean length of stay that we proposed would continue to be used for the period of July 1, 2003, through September 30, 2003. (This table is the same as Table 3 of the Addendum to the August 30, 2002, final rule (67 FR 56076–56084), except that it includes the proposed five-sixth of the average length of stay for short-stay outliers under § 412.529.) As we noted in section IV.D. of the March 7, 2003, proposed rule, we proposed that the final DRGs and GROUPER for FY 2004 that will be used for the IPPS and the LTCH PPS, effective October 1, 2003, would be presented in the IPPS FY 2004 final rule published no later than August 1, 2003, in the **Federal Register**.

Accordingly, we will notify LTCHs of the revised LTC-DRG relative weights for use in determining payments for discharges occurring between October 1, 2003, and September 30, 2004, based on the final DRGs and Version 21.0 GROUPER published in the IPPS rule on or before August 1, 2003.

VI. Policy Change Related to Payments to LTCHs That Are Satellite Facilities

Provisions of the Proposed Rule

In proposing the LTCH PPS (March 7, 2002, 67 FR 13416), we stated that we were considering proposing the elimination of the bed limit in § 412.22(h)(2)(i) for pre-1997 excluded hospitals once the prospective payment system was fully phased-in and all payments were based on 100 percent of the Federal prospective payment rates. This statement generated a number of comments and in the August 30, 2002, final rule (67 FR 56012), we stated our agreement with commenters who urged us to adopt a policy eliminating the bed-number restrictions for pre-1997 LTCHs with satellite facilities, as soon as a LTCH is paid based on 100 percent of the Federal prospective rate. However, we also noted that we would address a change in the policy concerning bed limits in the next update of the LTCH PPS. Therefore, in the March 7, 2003, proposed rule (68 FR 11243–11244), we proposed to eliminate the application of the bed-number restrictions set forth in § 412.22(h)(2)(i) for LTCHs established prior to 1997 with satellite facilities, effective at the start of the first cost