

reporting year that a LTCH is paid under the 100 percent fully Federal prospective payment system. This will be either when a LTCH elects to be paid based on 100 percent of the Federal prospective rate or when the LTCH is fully transitioned to 100 percent of the Federal prospective rate, whichever comes first.

Section 1886(b)(3) of the Act, as amended by section 4414 of Public Law 105–33, required existing LTCHs to be subject to caps on their target amounts for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. For purposes of calculating these caps, the statute required the Secretary to “estimate the 75th percentile of the target amounts for such hospitals within [each] class for cost reporting periods ending during fiscal year 1996.” Section 1886(b)(3)(H) of the Act, as amended by section 121 of Public Law 106–113, directed the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric and rehabilitation hospitals and units and LTCHs effective for cost reporting periods beginning on or after October 1, 1999 through September 30, 2002. In addition, payment limits were established for new excluded hospitals or units (excluding children’s hospitals) effective October 1, 1997. For new excluded hospitals (that is, post-1997 LTCHs), section 1886(b)(7) of the Act, as added by section 4416 of Public Law 105–33, specified that the payment amount for the facility’s first two 12-month cost reporting periods, for which the hospital has a settled cost report, must not exceed 110 percent of the national median of target amounts of similarly classified hospitals for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the first cost reporting period in which the hospital receives payment, as adjusted by section 1886(b)(7)(C) of the Act. The result of sections 4414 and 4416 of Public Law 105–33 was a distinction between the LTCHs established prior to, and those established after 1997, with lower payment caps for the post-1997 LTCHs.

In the July 30, 1999, IPPS final rule (64 FR 41532–41533), we promulgated regulations at § 412.22(h)(2)(i) to discourage pre-1997 excluded hospitals, which had the higher caps on target amounts as discussed above (under § 413.40(c)(4)(iii)), from creating satellites rather than establishing new hospitals, in order to avoid the payment impact of the lower caps that apply to new hospitals (under § 413.40(f)(2)(ii)). In the July 30, 1999, IPPS final rule (64

FR 41490), we required that where a pre-1997 excluded hospital, such as a LTCH, established a satellite facility and, in doing so, its total beds, in both the parent hospital (or unit) and the satellite facility, exceeded the number of State-licensed and Medicare-certified beds in the parent hospital on the last day of its last cost reporting period beginning before October 1, 1997, the excluded hospital would be paid under the inpatient DRG system, instead of receiving payment as an excluded hospital under the reasonable cost-based payment system. Although the excluded hospital could “transfer” beds from the parent facility to the satellite, it could not increase its total bed capacity (at the parent and satellite(s)) beyond the level the hospital had in the most recent cost reporting period beginning before October 1, 1997, and still be paid as a hospital excluded from the IPPS. However, no such limitation was imposed on a LTCH established after October 1, 1997. Since this type of hospital would have already been subject to the lower payment limit of 110 percent of the national median of target amounts for similarly classified hospitals under § 413.40(f)(2)(ii), it would not benefit by establishing a satellite facility instead of a separate free-standing hospital, as would a pre-1997 LTCH.

The rationale for applying the bed-limit provision only on pre-1997 hospitals was the potential for gaming by those hospitals, by creating a satellite facility with a higher TEFRA target cap where, in reality, the satellite facility should have been a separately certified excluded facility, which would have been subject to the lower cap on payments to new (post-1997) facilities paid under the TEFRA system. Once the LTCH is paid based on 100 percent of the Federal prospective rate, however, the LTCH will no longer be subject to TEFRA caps and LTCH prospective payments will be the same regardless of when the LTCH was established. Therefore, consistent with the March 7, 2003, proposed rule, we are eliminating the bed-limit provision once a LTCH is paid based on 100 percent of the LTCH Federal PPS rate. Finally, under this policy, the bed limitation on “existing” LTCHs will, however, continue to apply to those LTCHs while they are paid based on the transition blend, and, therefore, continue to receive a percentage of their payments based on the reasonable cost-based payment rules, until these hospitals are paid based on 100 percent of the Federal prospective payment rate.

Comment: Several commenters expressed their strong support for our

proposal to eliminate the bed number limitation for pre-1997 LTCHs with satellite facilities for those LTCHs receiving 100 percent of the Federal rate. One commenter recommended that the bed number limitation should also be eliminated for the IRFs since they are now receiving payment at 100 percent of the Federal rate.

Response: We appreciate the strong endorsement in response to this proposed change. Regarding the commenter who recommended eliminating the bed size limitation for IRFs, we would suggest that the commenter look to the IRF proposed rule that was published on May 16, 2003 (68 FR 26785).

Accordingly, in this final rule, we are adopting the proposal to eliminate the bed size limitation for pre-1997 LTCHs with satellite facilities once the LTCH is paid at 100 percent of the Federal rate. We note that in the preamble to the March 7, 2003, proposed rule, we stated the two circumstances under which a LTCH would be paid based on 100 percent of the Federal rate, which are for the start of the first cost reporting period that a LTCH elects fully Federal payment, as set forth in § 412.533(c) or when the LTCH PPS is fully phased-in after the transition period. We inadvertently omitted the second circumstance in the proposed regulation text at § 412.22(h)(6), therefore, we are revising that section to reflect this policy.

VII. Changes to the LTCH PPS Rates for the 2004 LTCH PPS Rate Year

A. Overview of the Development of the Payment Rates

The LTCH PPS was effective for a LTCH’s first cost reporting period beginning on or after October 1, 2002. Effective with that cost reporting period, LTCHs are paid, during a 5-year transition period, on the basis of an increasing proportion of the LTCH PPS Federal rate and a decreasing proportion of a hospital’s payment under reasonable cost-based payment system, unless the hospital makes a one-time election to receive payment based on 100 percent of the Federal rate (see § 412.533). New LTCHs (as defined at § 412.23(e)(4)) are paid based on 100 percent of the Federal rate, with no phase-in transition payments.

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth in the regulations at §§ 412.515 through 412.532. Below we discuss the proposed factors used to update the LTCH PPS standard Federal rate for the proposed 2004 LTCH PPS rate year published in