

existing policy in the IPPS high-cost outlier final rule. We believe that it is appropriate, however, to respond to three commenters that submitted comments regarding the impact of our short-stay outlier policy on certain hospitals which qualify as LTCHs under section 1886(d)(1)(B)(iv)(II) of the Act ("subclause (II)" LTCHs) as added by section 4417(b) of Public Law 105-33, and implemented in § 412.23(e)(2)(ii).

*Comment:* Three commenters, two hospital associations and the other, a hospital that qualifies as a LTCH under section 1886(d)(1)(B)(iv)(II) of the Act, expressed great concern that since becoming subject to the LTCH PPS, the LTCH is experiencing considerable financial losses which it anticipates will continue to increase during the 5-year transition period. The commenters assert that these mounting losses will substantially threaten the LTCH's ability to continue to offer services in accordance with its unique mission of primarily treating cancer patients. The commenters identify our payment policy for short-stay outliers as creating the most damaging shortfall, given this "subclause (II)" LTCH's case mix. In order to ameliorate this situation, all three commenters suggest that we exempt "subclause (II)" LTCHs, from the short-stay outlier policy and establish a hospital-specific standard Federal rate to reflect this change, which would also result in a lower average payment amount for all of those LTCHs' cases and a higher high-cost outlier threshold. We were urged, by one of the commenters to make these suggested policy modifications retroactive to the start of the hospital's first cost reporting period under the LTCH PPS and also to suspend the timing requirements of § 412.533(c), which would allow this LTCH to elect fully prospective payments as of that date. A suggestion from one of the hospital associations also advanced the possibility that the necessity for any adjustment to the short-stay outlier policy would end with the completion of the 5-year transition because with implementation of the full wage index adjustment and no budget neutrality adjustment (to account for the costs incurred by the Medicare program during the transition), Medicare payments for the "subclause (II)" LTCH would be more in line with the costs of delivering care.

*Response:* By enacting section 4417(b) of Public Law 105-33, and adding the provision at section 1886(d)(1)(B)(iv)(II) of the Act, the Congress provided an exception to the general definition of LTCH as set forth in section 1886(d)(1)(B)(iv)(I) of the Act

("subclause (I)" LTCHs), intending, we believe, to recognize the existence and importance of a distinct category of LTCHs that might not otherwise warrant exclusion from the IPPS under subclause (I), but which, nonetheless, fulfills a unique and vital role in serving a particular subset of Medicare patients. Under this provision, which we implemented at § 412.23(e)(2)(ii), to qualify as a LTCH, a hospital must have first been excluded as a LTCH in 1986, have an average inpatient length of stay of greater than 20 days, and demonstrate that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending in Federal fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease (62 FR 46016 and 46026, August 29, 1997). Moreover, we believe the Congress assumed "subclause (II)" LTCHs would continue to serve this population after FY 1997.

Acknowledging the distinction between hospitals qualifying as LTCHs under section 1886(d)(1)(B)(iv)(I) of the Act, and those qualifying under section 1886(d)(1)(B)(iv)(II) of the Act when we developed the LTCH PPS, we revised the greater than 25 day average length of stay criteria to include only Medicare patients for these "subclause (I)" LTCHs. However, for LTCHs described in section 1886(d)(1)(B)(iv)(II) of the Act, no change was made to the methodology for calculating the LTCH's average length of stay, since "we have no reason to believe that the change in methodology for determining the average inpatient length of stay would better identify the hospitals that the Congress intended to exclude under subclause (II)" (67 FR 55974, August 30, 2002). Consistent with existing policies that differentiate "subclause (II)" LTCHs from other LTCHs, we agree with the commenters that it is appropriate for us to consider whether or not a policy that applies to LTCHs designated under subclause I, can reasonably and equitably be applied to "subclause (II)" LTCHs without some measure of adjustment. We also believe that the specificity of section 4417(b) of Public Law 105-33, which states that 80 percent or more of the annual Medicare inpatient discharges, in such a "subclause (II)" LTCH, in the 12-month reporting period ending in Federal fiscal year 1997 would have had a principal diagnosis that reflects a finding of neoplastic disease, indicates to us that the Congress determined that hospitals fitting this description fulfilled a unique and vital service for certain Medicare beneficiaries. Furthermore, we believe the Congress assumed that not only

would a "subclause (II)" LTCH have at least 80 percent of its Medicare inpatient discharges with a diagnosis of neoplastic disease in FY 1997, but this type of LTCH would continue to serve this patient case-mix in years subsequent to FY 1997.

The theoretical foundations of a DRG-based PPS are that while the costs of one case may exceed its payment, the opposite is also likely to happen, and that where some types of cases are always very expensive for a hospital to treat, others are, in general, not costly. It is assumed that hospitals under a DRG-based system, therefore, can typically exercise some influence over their case-mix and their services in order to achieve fiscal stability. This is not generally the case for "subclause (II)" LTCHs because they continue to primarily treat patients with neoplastic diseases (97.4 percent of patients at a "subclause (II)" LTCH had primary diagnosis of neoplastic disease, according to data from FY 2001 MedPAR files.). According to our claims data for January 1, 2001, through December 31, 2001, at a "subclause (II)" LTCH, more than 93 percent of its Medicare patients expired, over half of the patients at this hospital would qualify as short-stay outliers (97 percent of those short-stay outliers expired), and 30 percent of its patient days were for high-cost outlier patients with an average length of stay of 109 days.

We have analyzed our data as well as information supplied by the commenters in order to better understand the financial impact on a "subclause (II)" LTCH of the payment policies established for LTCHs that will be in place during the 5-year transition to the full LTCH PPS. In identifying this category of LTCHs, Congress required that "in the 12-month cost reporting period ending in fiscal year 1997" the Medicare patient population would be comprised of at least 80 percent with " \* \* \* a principal diagnosis that reflects a finding of neoplastic disease." As noted above, our data indicates that the treatment of neoplastic diseases continues to be the mission of a "subclause (II)" LTCH. Accordingly we believe that the patient census at a "subclause (II)" LTCH will, by its very nature, be comprised of unusually high percentages of both short-stay cases as well as high-cost outliers. Data projections further reveal that the significant losses that are being incurred will gradually decline throughout the 5-year transition, as the percentage of payments based on the Federal rate increase and the effect of the wage index adjustment is fully transitioned. Our analyses lead us to believe that until the