

full wage index is phased-in in 2006 and the transition period budget neutrality adjustments cease, the survival of such a "subclause (II)" LTCH is in serious jeopardy.

By establishing "subclause (II)" LTCHs, the Congress provided an exception to the general definition of LTCH under subclause (I), and, therein, we believe, endorsed the unique mission of a particular type of hospital. We do not believe that the Congress intended for policies that equitably apply to LTCHs described under subclause (I) to potentially undermine the viability of a LTCH described under subclause (II).

In the August 30, 2003, final rule (67 FR 55954), we stated that we believed that in establishing the short-stay outlier policy under the LTCH PPS, we were recognizing that LTCHs, as a provider category under Medicare, should not be admitting patients whose stay were considerably less than the average length of stay at a LTCH and who could otherwise receive care at an acute care hospital subject to the IPPS. Data from the FY 1999 MedPAR files revealed that 52 percent of cases being treated at LTCHs were for stays of less than two-thirds of the average length of stay for the LTC-DRG and 20 percent had a length of stay of even less than 8 days (67 FR 55970, August 30, 2002). We noted, however, that short-stay outliers could also result from a legitimate admission to a LTCH when a change in the patient's condition dictated that another treatment or care setting would be more clinically appropriate or if the patient expired early in the LTCH stay. In these situations, the patient would still not have received the full course of treatment at the LTCH and paying a full LTC-DRG would result in significant overpayment. Therefore, we created the short-stay outlier category as a feature of the LTCH PPS, so that Medicare would be rendering fair, but not excessive payment for patients who could have received treatment at an acute care hospital as well as for patients who, for valid clinical reasons, did not stay long enough at a LTCH to receive the course of treatment for which the full LTC-DRG payments were calibrated. We further believed that implementing the short-stay policy could encourage LTCHs to adopt admission policies that, for the most part, would work to limit the number of short-stay patients since there would be no inappropriate financial incentive for admitting such cases.

As we evaluate the short-stay outlier policy with regard to "subclause (II)" LTCHs, we believe that a LTCH in this category may not be able to readily

address the length of stay of patients and the costs it incurs for those patients as would LTCHs described under subclause (I) because a "subclause (II)" LTCH continues to primarily serve patients with neoplastic diseases. In fact, as previously noted, FY 2001 MedPAR data demonstrate that 97.4 percent of the patients at a "subclause (II)" LTCH have a primary diagnosis of neoplastic disease. Accordingly, we believe that it is necessary to adjust the short-stay policy for "subclause (II)" LTCHs during the 5-year transition period, so that a LTCH of this type can continue to serve its community, as we believe was assumed by the Congress when it established this category of LTCHs.

All three commenters suggested that we abrogate the entire short-stay outlier policy for "subclause (II)" LTCHs, which would result in a revised hospital-specific standard Federal rate and high-cost outlier threshold. We do not believe that such a radical departure from the general LTCH PPS policies is either necessary or appropriate to address the problems that we have noted.

In the August 30, 2002, final rule (67 FR 55995-56000), we describe the simulations that resulted in our short-stay outlier policy of the lesser of 120 percent of the cost, 120 percent of the per diem amount of the LTC-DRG, or the full LTC-DRG. Since these simulations were established by analyzing costs and payments of a LTCH with a greater than 25 day average length of stay, we are instead providing an adjustment to the short-stay outlier payment policy for a "subclause (II)" LTCH, which is held to a greater than 20 day average length of stay criterion and not to the greater than 25 day average length of stay criterion which applies to "subclause (I)" LTCHs. Furthermore, this adjustment to the short-stay payment policy will be in place during "subclause (II)" LTCHs' 5-year transition to full LTCH PPS in the form of percentages, corresponding to the 120 percent for "subclause (I)" LTCHs, and it will be "phased out" gradually as the percentage of payments under the LTCH PPS are increased, the full wage index adjustment is phased-in, and the budget neutrality adjustment is decreased. The adjustment, described below, was derived based on payment simulations using the same methodology on "subclause (II)" LTCH data that we used in arriving at the 120 percent for "subclause (I)" LTCHs. (67 FR 55995-56000, August 30, 2002)

We are establishing this formula with the expectation that an adjustment to the short-stay payments during the

transition will result in reducing the difference between payments and costs for a "subclause (II)" LTCH for the period of July 1, 2003, through the end of the transition period, when the LTCH PPS will be fully phased-in. Therefore, for example, a "subclause (II)" LTCH, which became subject to the LTCH PPS for their first cost reporting period which began on January 1, 2003 (and did not elect payment based on 100% of the Federal rate), 80 percent of Medicare payments would still be based on what would have been paid under the TEFRA system and only 20 percent would be based on the Federal rate (and subject to payments under the short-stay outlier policy established in the August 30, 2002, final rule). Effective for discharges from a "subclause (II)" LTCH occurring on or after July 1, 2003, and based on the payment simulations described above, we have revised the short-stay outlier percentage to 195 percent during the first year of the hospital's 5-year transition. For the second cost reporting period, the short-stay outlier percentage will be 193 percent; for the third cost reporting period, the percentage will be 165 percent; for the fourth cost reporting period, the percentage will be 136 percent; and for the final cost reporting period of the 5-year transition, the short-stay outlier percentage for "subclause (II)" LTCHs, will be 120 percent, that is, the same as it is for all other LTCHs under the LTCH PPS. We have set forth this policy by redesignating the existing paragraph (c)(4) as (c)(5) and adding a new paragraph (c)(4) to § 412.529.

We also expect that during this 5-year period, "subclause (II)" LTCHs will make every attempt to adopt the type of efficiency enhancing policies that generally result from the implementation of prospective payment systems in other health care settings.

We consider the above adjustment to be a reasonable, equitable and sufficient response to the particular situation of a "subclause (II)" LTCH under the LTCH PPS and, therefore, we will not address at any length the other two suggestions regarding retroactive adjustments to the start of a LTCH's first cost reporting period under the LTCH PPS and the disregarding of timing requirements established in § 412.533(c) for election not to be paid under the transition period methodology. In this final rule, therefore, we are making a temporary adjustment to payments under the short-stay outlier policy for LTCHs designated under section 1886(d)(1)(B)(iv)(II) of the Act and § 412.23(e)(2)(ii) that will end upon full implementation of the LTCH PPS, at the beginning of their fifth cost reporting period in the 5-year transition period.