

calculated by comparing the average charge for cases within each DRG (after removing statistical outliers) with the national average charge per case. Therefore, there are several factors that can cause a shift in the relative weight of a DRG from one fiscal year to the next. For example, even though the average charges of cases within a particular DRG may have increased, if they did not increase by an equal or greater percentage than the national average, the DRG relative weight would decline. In this final rule, the weights for 223 DRGs for FY 2004 decline from those for FY 2003 (all but 38 DRGs by less than 5 percent), while the weights for 299 DRGs for FY 2004 increased from those for FY 2003 (all but 39 DRGs by less than 5 percent).

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.a. of the Addendum to this final rule, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Comment: One commenter expressed concern that the impact of the proposed DRG recalibration is a \$3 million decrease in payments to its hospitals. The commenter was hopeful that the budget neutrality adjustment to ensure that the normalization of DRG weights is achieved will somehow restore the estimated negative impact.

Response: As explained above and in the proposed rule, section 1886(d)(4)(C)(iii) of the Act requires that the changes made through DRG reclassification and recalibration be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payment that would have been made without the changes. However, this requirement refers to aggregate national payments. Therefore, for individual hospitals, the impacts of these changes may be either positive or negative.

D. LTC-DRG Reclassifications and Relative Weights for LTCHs for FY 2004

1. Background

In the June 6, 2003 LTCH PPS final rule (68 FR 34122) we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, since the patient classification system utilized under the LTCH PPS is based directly on the DRGs used under the IPPS for acute care hospitals, in that same final rule, we explained that the annual update of the long-term care diagnosis-related group (LTC-DRG) classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the CMS-DRGs under the IPPS.

The annual update to the IPPS DRGs is based on the annual revisions to the ICD-9-CM codes and is effective each October 1. In the health care industry, annual changes to the ICD-9-CM codes are effective for discharges occurring on or after October 1 each year. The use of the ICD-9-CM coding system is also compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104-191, under 45 CFR parts 160 and 162. Therefore, the manual and electronic versions of the GROUPE software, which are based on the ICD-9-CM codes, are also revised annually and effective for discharges occurring on or after October 1 each year. Because the LTC-DRGs are based on the patient classification system used under the IPPS (CMS-DRGs), which is updated annually and effective for discharges occurring on or after October 1 through September 30 each year, in the June 6, 2003 LTCH PPS final rule (68 FR 34128), we specified that we will continue to update the LTC-DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. Furthermore, we stated that we will publish the annual update of the LTC-DRGs in the proposed and final rules for the IPPS.

As we explained in the May 19, 2003 IPPS proposed rule (68 FR 27173), we proposed revisions to the LTC-DRG classifications and relative weights and indicated that we would finalize them in the IPPS final rule, to be effective October 1, 2003 through September 30, 2004. The final LTC-DRGs and relative weights for FY 2004 in this final rule are based on the IPPS DRGs (GROUPE version 21.0) discussed in section II. of this final rule.

2. Changes in the LTC-DRG Classifications

a. Background

Section 123 of Pub. L. 106-113 specifically requires that the PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Pub. L. 106-554 modified the requirements of section 123 of Pub. L. 106-113 by specifically requiring that the Secretary examine "the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data."

In accordance with section 307(b)(1) of Pub. L. 106-554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC-DRGs based on clinical characteristics and expected resource needs. The LTC-DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs under the IPPS for acute care hospitals. Thus, under this final rule, we will use the IPPS version 21.0 GROUPE for FY 2004 to process LTCH PPS claims. The changes to the IPPS DRG classification system for FY 2004 (Grouper 21.0) are discussed in section II.B. of this preamble.

Under the LTCH PPS, we determine relative weights for each of the IPPS DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. In a departure from the IPPS, as we discussed in both the May 19, 2003 proposed rule (68 FR 27174) and the June 6, 2003 LTCH PPS final rule (68 FR 34132), we use low volume quintiles in determining the LTC-DRG weights for LTC-DRGs with less than 25 LTCH cases, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. In order to deal with the large number of low volume LTC-DRGs (LTC-DRGs with fewer than 25 cases), as we discussed in the May 19, 2003 proposed rule (68 FR 27176), we group those low volume LTC-DRGs into 5 quintiles based on average charge per discharge. (A listing of the composition of low volume quintiles for the FY 2004 LTC-DRGs (based on FY 2002 MedPAR data) appears in section II.D.3. of this final