DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

CMS-1493-IFC

RIN 0938-AP33

Medicare Program; Changes for Long-Term Care Hospitals Required by Certain Provisions of the Medicare, Medicaid, SCHIP Extension Act of 2007: 3-Year Delay in the Application of Payment Adjustments for Short Stay Outliers and Changes to the Standard Federal Rate

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements certain provisions of section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 relating to long term care hospitals (LTCHs). These provisions include a 3-year delay in the application of certain provisions of the payment adjustment for short-stay outliers and revisions to the RY 2008 standard Federal rate.

DATES: Effective date: The provisions of §412.1 and §412.500 are effective [OFR--insert 30 days after date of publication.] The provisions of §412.529(c)(1) through (c)(3) are effective on December 29, 2007. In accordance with section 1871(e)(1)(A)(i) and (ii) of the Social Security Act (the Act), the Secretary has determined that retroactive application of the provisions of §412.529(c)(1) through (c)(3) is necessary to comply with the statute and that failure to apply the changes retroactively would be contrary to public interest. Also, in accordance with section 1871(e)(1)(A)(ii) of the Act, the technical corrections to §412.529(f) are effective on December 29, 2007. In accordance with section 1871(e)(1)(A)(ii) of the Act, the Secretary has determined that failure to apply the technical corrections in §412.529(f) retroactively would be contrary to public interest. Additionally, in accordance with section 1871(e)(1)(A)(i) and (ii) of the Act, the provisions of §412.523 are effective April 1, 2008. Also, in accordance with section 1871(e)(1)(A)(ii) of the Act, the fixed loss-amount provision in section II.D.2. of this preamble which revises the fixed-loss amount for discharge occurring on or after April 1, 2008 and through June 30, 2008 is effective April 1, 2008.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR--insert 60 days after the date of filing for public inspection at OFR.]

ADDRESSES: In commenting, please refer to file code CMS-1493-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX)

transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions for "Comment or Submission" and enter the filecode to find the document accepting comments.

2. By regular mail. You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1493-IFC,

P.O. Box 8013,

Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1493-IFC,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. 7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit

comments on this document's paperwork requirements by following instructions at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Tzvi Hefter, (410) 786-4487, General information

Michele Hudson, (410) 786-5490, General information

Elizabeth Truong, (410) 786-6005, Federal rate update and short stay outlier

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on the Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

A. Legislative and Regulatory Authority

Section 123 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113), as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554), provides for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002.

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days." Section 1886(d)(1)(B)(iv)(II) of the Act also provides an alternative definition of LTCHs: specifically, a hospital that first received payment under section 1886(d) of the Act in 1986 and has an average inpatient length of stay (LOS) (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year (FY) 1997.

Section 307(b)(1) of the BIPA, among other things, mandates that the Secretary

shall examine, and may provide for, adjustments to payments under the LTCH PPS, including adjustments to diagnosis related group (DRG) weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

In the August 30, 2002 **Federal Register**, we issued a final rule that implemented the LTCH PPS authorized under BBRA and BIPA (67 FR 55954). This system uses information from LTCH patient records to classify patients into distinct long-term care diagnosis-related groups (LTC-DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each LTC-DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

In the August 30, 2002 final rule, we also presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments (short-stay outliers), and the budget neutrality requirements mandated by section 123 of the BBRA. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, subpart O, also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements. We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS (67 FR 55954).

In the June 6, 2003 **Federal Register**, we published a final rule that set forth the FY 2004 annual update of the payment rates for the Medicare PPS for inpatient hospital services furnished by LTCHs (68 FR 34122). It also changed the annual period for which the payment rates are effective. The annual updated rates are now effective from July 1 through June 30 instead of from October 1 through September 30. We refer to the July through June time period as a "long-term care hospital rate year" (LTCH PPS rate year (RY)). In addition, we changed the publication schedule for the annual update to allow for an effective date of July 1. The payment amounts and factors used to determine the annual update of the LTCH PPS Federal rate are based on a LTCH PPS rate year. While the LTCH payment rate update is effective July 1, the annual update of the DRG classifications and relative weights for LTCHs are linked to the annual adjustments of the acute care hospital inpatient DRGs and are effective each October 1.

The most recent annual update to the LTCH PPS was presented in the RY 2008 LTCH PPS final rule (72 FR 26870 through 27029). In that final rule, among other things, we established a 0.71 percent update to the Federal rate for RY 2008, as well as revising the existing payment formula for certain short-stay outlier (SSO) cases and the establishment of a payment adjustment policy applicable to LTCH and LTCH satellite facility discharges that were admitted from hospitals that are not co-located with the LTCH or LTCH satellite facility and that exceed a certain percentage threshold. In addition, in the January 29, 2008 **Federal Register**, we presented the annual proposed

rule for RY 2009. Among other things, this proposed rule presented a proposed update for RY 2009 and other proposed payment rate and policy changes.

On December 29, 2007 the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) (Pub. L. 110-173) was enacted. Specifically, section 114 of MMSEA, entitled "Long-term care hospitals," made a number of changes affecting payments to LTCHs for inpatient services. Several of the provisions of section 114 of MMSEA are discussed in this interim final rule with comment period.

B. Criteria for Classification as a LTCH

Under the existing regulations at §412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient LOS of greater than 25 days. Alternatively, §412.23(e)(2)(ii) states that for cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the PPS in 1986 and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient LOS for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days.

Section 412.23(e)(3) currently provides that, subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average Medicare inpatient LOS, specified under §412.23(e)(2)(i) is calculated by dividing the total number of

covered and noncovered days of stay for Medicare inpatients (less leave or pass days; that is, days where the inpatient is not occupying a bed but has not been discharged) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period. Currently, §412.23 also provides that subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average inpatient LOS specified under §412.23(e)(2)(ii) is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period. The fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) verify that LTCHs meet the average LOS requirements. We note that the inpatient days of a patient who is admitted to a LTCH without any remaining Medicare days of coverage, regardless of the fact that the patient is a Medicare beneficiary, will not be included in the above calculation. Because Medicare would not be paying for any of the patient's treatment, data on the patient's stay would not be included in the Medicare claims processing systems. As described in §409.61, in order for both covered and noncovered days of a LTCH hospitalization to be included, a patient admitted to the LTCH must have at least 1 remaining-benefit day. (For a more detail explanation, see the June 6, 2003 final rule (68 FR 34123).)

The FI's or MAC's determination of whether or not a hospital qualifies as an LTCH is based on the hospital's discharge data from the hospital's most recent complete cost reporting period as specified in §412.23(e)(3) and is effective at the start of the

hospital's next cost reporting period as specified in §412.22(d). However, if the hospital does not meet the average LOS requirement as specified in §412.23(e)(2)(i) and (ii), the hospital may provide the FI or MAC with data indicating a change in the ALOS by the same method for the period of at least 5 months of the immediately preceding 6-month period (69 FR 25676). Our interpretation of existing §412.23(e)(3) is to allow hospitals to submit data using a period of at least 5 months of the most recent data from the immediately preceding 6-month period.

II. Provisions of this Interim Final Rule with Comment Period

Section 114 of MMSEA made a number of changes affecting payments to long-term care hospitals (LTCHs) for inpatient services. This interim final rule with comment period will implement the following provisions affecting LTCH PPS payments:

• Modification of payment adjustments to certain SSO cases. Section 114(c)(3) of MMSEA specifies that the refinement of the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Specifically, the fourth SSO payment option in §412.529(c)(3)(i) shall not apply for a 3-year period, as discussed in section II.B. of this interim final rule with comment period.

• Revision to the RY 2008 rate provision. Section 114(e)(1) of MMSEA provides that the base rate for RY 2008 "shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007." Furthermore, in accordance with section 114(e)(2) of MMSEA, the revised rate will not be applicable to

discharges occurring on or after July 1, 2007 and before April 1, 2008. (See section II.C. of this interim final rule with comment period.)

We also note that section 114(c)(4) of MMSEA specifies that for a 3-year period beginning on December 29, 2007, the Secretary shall not make the one-time prospective adjustment to the LTCH PPS payment rates provided for in existing §412.523(d)(3). Since under existing regulations the one-time prospective adjustment would have impacted the update to the standard Federal rate for RY 2009, we have addressed this provision in the LTCH PPS RY 2009 January 29, 2008 proposed rule (73 FR 5353 through 5360). While we did not propose the one-time prospective adjustment in the RY 2009 proposed rule, we provided a possible methodology for determining whether the one-time prospective adjustment would be warranted. We solicited comments on the methodology and indicated that we would take these comments into consideration in proposing to implement a one-time prospective adjustment on or after December 29, 2010, consistent with the requirements of section 114(c)(4) of MMSEA. Additionally, section 114(d) of MMSEA established a 3-year moratorium on the establishment and classification of new LTCHs, LTCH satellite facilities, and on any increase in beds in existing LTCHs and LTCH satellite facilities, with certain exceptions. Section 114(c)(1) and (2) of MMSEA established a 3-year delay in the application of certain payment policies which apply a payment adjustment for LTCH patients admitted from certain referring hospitals that exceed various percentage thresholds. These provisions will be addressed in separate rulemaking.

We would also note that section 114 of MMSEA included additional provisions focusing on LTCHs not directly related to payment policy that are not in this interim final rule with comment period are as follows:

• Section 1861 of the Act is amended by adding a new paragraph (ccc) defining LTCHs.

• The Secretary is directed to conduct a study and submit a report to the Congress within 18 months after the date of enactment of MMSEA. The Secretary will conduct a study on the establishment of national LTCH facility and patient criteria.

• The Secretary is directed to provide an expanded review of medical necessity for LTCH admission and continued stay.

A. Scope of the LTCH Regulations and Section 114 of MMSEA

Section 114(e)(1) of MMSEA amended section 1886 of the Act by adding a new subsection m. New section 1886(m)(1) of the Act provides that for provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv) (see section 123 of BBRA and section 307(b) of BIPA.) In addition, it added new section 1886(m)(2) of the Act, which pertains to the standard Federal rate for RY 2008. We are revising our regulations at §412.1(a)(4) and §412.500, which contain the scope of the long-term care hospital regulations to reference the statutory authority provided by section 114 of MMSEA and to reference the amendment to section 1886 of the Act.

B. Short Stay Outlier (SSO) Cases

1. Background

In the RY 2003 LTCH PPS final rule (67 FR 55995), we established at §412.529 a special payment policy for short-stay outlier (SSO) cases, SSO cases are cases with a covered LOS that is less than or equal to five-sixths of the geometric average LOS for each LTC-DRG. When we established the SSO policy, we explained that "[a] short stay outlier case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged" (67 FR 55995). Therefore, under the LTCH PPS, we implemented a special payment adjustment for SSO cases. Under the SSO policy established in the RY 2003 LTCH PPS final rule (67 FR 55995 through 56000), for LTCH PPS discharges with a covered LOS of up to and including five-sixths the geometric average LOS for the LTC-DRG, we adjusted the per discharge payment under the LTCH PPS by the least of the following three options: (1) 120 percent of the estimated cost of the case; (2) 120 percent of the LTC-DRG specific per diem amount multiplied by the covered LOS of that discharge; or (3) the full LTC-DRG payment.

Generally LTCHs are defined by statute as having an average LOS of greater than 25 days. We believe that since a SSO case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged, the full LTC-DRG payment would generally not be appropriate. Accordingly, based on an evaluation of data from more than 3 years of the LTCH PPS which revealed that a large percentage of SSOs had a covered LOS of 14 days or less, we further revised our payment policy for

SSO cases in the RY 2007 and RY 2008 LTCH PPS final rules (71 FR 27845 through 27870 and 72 FR 26904 through 26918) for LTCHs defined by section 1886(d)(1)(B)(iv)(I) of the Act. However, as we discussed in detail in the RY 2007 and RY 2008 LTCH PPS final rules (71 FR 27863 and 72 FR 26907), we did not believe that it was appropriate to apply our RY 2007 and RY 2008 SSO policy revisions, discussed below, to the unique situation of a LTCHs defined by section 1886(d)(1)(B)(iv)(II) of the Act.

For RY 2007, consistent with the Secretary's broad authority "to provide for appropriate adjustments to the long-term hospital payment system ..." established under section 123 of the BBRA as amended by section 307(b)(1) of BIPA, we reduced the cost-based option of the SSO policy adjustment to 100 percent of the estimated costs of the case for discharges occurring on or after July 1, 2006. Furthermore, in the RY 2007 LTCH PPS final rule, we added a fourth payment option to the SSO policy, following an analysis of the FY 2004 MedPAR data that indicated that even under the existing SSO policy, LTCHs were admitting short stay patients that we believe could have continued treatment at the acute care hospitals (paid for under the IPPS). Furthermore, we believe that these types of admissions (that is, of patients from acute care hospitals that result in short stay cases at the LTCH) could result in unnecessary and inappropriate admissions to LTCHs. This fourth payment alternative is a blend of an LTCH PPS amount that is comparable to the IPPS per diem payment amount, and the 120 percent of the LTC-DRG per diem payment amount. Specifically, the blended payment is based on a percentage of

an IPPS comparable amount computed as a per diem and capped at the full IPPS-comparable amount, and a percentage of a payment based on 120 percent of the LTC-DRG per diem amount so that as the length of the stay increases, the percentage of the IPPS comparable per diem amount will decrease and the percentage based on 120 percent of the LTC-DRG per diem specific amount will increase. This reflects our belief that as the length of a SSO stay increases, the case begins to resemble a more 'typical' LTCH stay and, therefore, it is appropriate that incrementally, payment should be based more on what would otherwise be payable under the LTCH PPS and less on the "IPPS-comparable" amount. (Specifics of calculating the "IPPS-comparable" amount are set forth in considerable detail in the RY 2007 LTCH PPS final rule (71 FR 27852 through 27853).)

In the RY 2008 LTCH PPS final rule (72 FR 26904 through 26918), we further revised the SSO policy based upon additional analysis of the FY 2005 MedPAR data. Specifically, our analysis revealed that 42 percent of LTCH SSO discharges, or approximately 19,750 cases, had covered lengths of stay that were less than or equal to the ALOS plus one standard deviation of an IPPS discharge for the same DRG as the LTC-DRG to which the case was assigned. (For additional discussion of this specific determination, see the RY 2008 LTCH PPS final rule (72 FR 26905).) At that time, we stated that we believed that the 42 percent of LTCH SSO cases in the RY 2005 MedPAR files with LOS that are equal to or less than the IPPS average LOS plus one standard

deviation for the same DRGs under the IPPS appeared to be comparable to typical stays at acute care hospitals.

For this subgroup of SSO cases, we stated that even with the blend option, we believe that payment in excess of what Medicare would have paid under the IPPS is inappropriate. (We note that in the FY 2008 IPPS final rule (72 FR 47130) the Medicare severity-diagnosis related groups (MS-DRGs) and the Medicare severity-long-term care-diagnosis related groups (MS-LTC-DRGs) were adopted for the IPPS and the LTCH PPS, respectively. Therefore, for SSO policies that are applicable to LTCH discharges occurring on or after October 1, 2007, all references to DRGs and LTC-DRGs should be understood to represent MS-DRGs and MS-LTC-DRGs (see §412.503). Accordingly, in the RY 2008 LTCH PPS final rule we established an alternative fourth payment option for SSO cases under the LTCH PPS for discharges occurring on or after July 1, 2007. Specifically, the covered LOS of a SSO case which has been assigned to a particular MS-LTC-DRG is compared to the average LOS plus one standard deviation for the same DRG under the IPPS, which we call "IPPS comparable threshold." For example, if the covered LOS of the LTCH SSO case is equal to or less than the average LOS plus one standard deviation for the same DRG under the IPPS, the LTCH SSO case would be within the "IPPS comparable threshold" (72 FR 26870 and 26906). We note that the "IPPS-comparable threshold" is only applicable if a particular stay is a SSO, that is, with a covered LOS equal to or less than five-sixth of the average LOS of the applicable MS-LTC-DRG. Thus, for a LTCH SSO

case that is within the "IPPS comparable threshold," the fourth payment option would be based on an amount comparable to the hospital IPPS per diem amount determined under §412.529(d)(4). For a SSO case with a covered LOS that exceeds the "IPPS-comparable" threshold, the fourth payment option continues to be the "blend" established in RY 2007, described above. For all SSO cases, the first three SSO payment options are the same. To summarize, as established in §412.529, for each SSO case treated at a LTCH defined under section 1886(d)(1)(B)(iv)(I), Medicare will pay the least of the following:

- 100 percent of the estimated cost of the case.
- 120 percent of the LTC-DRG specific per diem amount multiplied by the covered LOS of the particular case.
- The full LTC-DRG.
- Comparing the covered LOS for a SSO case and the "IPPS comparable threshold" one of the following:

++ The blend of the 120 percent of the LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount specified in §412.529(c)(2)(iv), for cases where the covered LOS for a SSO case is greater than the "IPPS comparable threshold".

++ An amount comparable to the hospital IPPS per diem amount determined under §412.529(d)(4) for cases where the covered LOS for a SSO is less than or equal to the "IPPS comparable threshold."

We note that the revisions of the SSO policy payment options that were finalized

beginning in RY 2007, (that is, the "blend" and reduction of the 120 percent of the estimated cost to 100 percent), and RY 2008 (the "IPPS-comparable" threshold option) were not applied to the unique situation of a hospital designated as a LTCH by the Congress under section 1886(d)(1)(B)(iv)(II) of the Act, that is, (a "subclause (II)" LTCH) (71 FR 27863 and 72 FR 26907).

2. Change to the SSO Policy due to the Medicare, Medicaid, and SCHIP Extension Act of 2007

Section 114(c)(3) of MMSEA provides that "[t]he Secretary shall not apply, for the 3-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision." Accordingly, for discharges beginning on or after December 29, 2007 and before December 29, 2010, the fourth SSO payment option based on the "IPPS comparable threshold" as discussed above shall not apply. Specifically, during the 3-year period specified above, for each SSO case treated at a LTCH defined under section 1886(d)(1)(B)(iv)(I) of the Act, Medicare will pay the least of: (1) 100 percent of the estimated cost of the case; (2) 120 percent of the LTC-DRG specific per diem amount multiplied by the covered LOS of the particular case; (3) the full LTC-DRG; or (4) the blend of the 120 percent of the LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount specified in §412.529(c)(2)(iv).

Accordingly, we are amending the appropriate regulations pertaining to the payment of SSO to implement section 114(c)(3) of MMSEA. Specifically, we made several heading changes and redesignated paragraph (c)(4), which refers to the policy for reconciliation of SSO payments, as the new paragraph (f). We note that we have not made any substantive changes to the policy for reconciliation of SSO payment (other than those associated with implementing section 114(c)(3) of MMSEA) and that the redesignation of the paragraph (c)(4) as (f), in addition the heading changes are simply reorganizational changes intended to make the regulations in this section more accessible. We also note that in amending the regulations, we discovered that several citations under existing paragraph (c)(4) were incorrect, originating from the RY 2008 final rule when we redesignated this paragraph from (c)(3) to (c)(4) (which was also an organizational change and not a substantive policy change to the policy on reconciliation of SSO payment) but inadvertently did not change the citations to correspond to the redesignation. In this interim final rule with comment period, we have corrected the citations in the redesignated paragraph (f).

C. Standard Federal Rate for the 2008 LTCH PPS Rate Year

1. Background

As specified at §412.523(c)(3)(ii), for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate by a factor to adjust for the most recent estimate of the increases in prices of an appropriate market basket of goods and services for LTCHs. When we moved the date of the annual update of the LTCH PPS

from October 1 to July l in the RY 2004 LTCH PPS final rule (68 FR 34126 through 34128), we revised §412.523(c)(3) accordingly.

In the RY 2007 LTCH PPS final rule (71 FR 27818), we explained that rather than solely using the most recent estimate of the LTCH PPS market basket as the basis of the update factor for the Federal rate at RY 2007, we believed it is appropriate to adjust the Federal rate to account for the changes in case mix that are due to changes in coding practices (rather than an increase in patient severity) as indicated by our ongoing monitoring activities. We established at §412.523(c)(3)(iii) that the update to the standard Federal rate for the 2007 LTCH PPS rate year was zero percent, based on the most recent estimate of the LTCH PPS market basket at the time and an adjustment to account for changes in case-mix in prior periods that are due to changes in coding practices, rather than increased patient severity, in FY 2004. Therefore, effective from July 1, 2006 through June 30, 2007, the standard rate was $38,086 (71 FR 27818). For the following year, we also considered changes in case mix in 2005 as opposed to 2004 that were due to changes in coding practices (rather than increased patient severity) in establishing the update to the Federal rate for the 2008 LTCH PPS rate year. In the RY 2008 LTCH final rule (72 FR 26887 through 26890), we adjusted the Federal rate based on the most recent estimate of market basket (3.2 percent) and an adjustment to account for changes in coding practices (2.49 percent) in FY 2005. Accordingly, we established at §412.523(c)(3)(iv) that the update to the standard Federal rate for RY 2008 was 0.71 percent and we established the LTCH PPS standard Federal rate, effective from

July 1, 2007 through June 30, 2008, at $38,356.45 (see 72 FR 26890).

2. Section 114(e)(1) and (2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007

Section 114(e)(1) of MMSEA revises the base rate for RY 2008. Specifically, section 114(e)(1) of Pub. L. 110-173 adds a new subsection 1886(m)(2) of the Act, which provides that the base rate for RY 2008 "shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007." In addition, section 114(e)(2) of Pub. L. 110-173 indicates that section 1886(m)(2) of the Act "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008" (that is, the first 9 months of RY 2008). We note that the statute uses the term "base rate," which is an undefined term in both section 1886(m) of the Act and in 42 CFR Part 412, subpart O. As we explained in the LTCH PPS RY 2009 proposed rule (73 FR 5361), we are interpreting that term to be the standard Federal rate because we believe Congress meant to eliminate the 0.71 percent update from the RY 2008 standard Federal rate. Under this interpretation, the standard Federal rate for RY 2008 would be the same as the standard Federal rate for RY 2007, that is, the 0.71 percent update finalized in the RY 2008 LTCH PPS final rule would be reversed.

We do not believe that the term "base rate" could refer to the "unadjusted rate" because the unadjusted rate for RY 2008 would be updated by the current year’s update factor in order to determine the standard Federal rate for RY 2008 (that is, to determine the standard Federal rate for any given rate year, the previous year’s standard Federal

rate, referred herein as the "unadjusted rate", is updated by the current year's update factor) and doing so would result in the same Federal rate for RY 2008 as was adopted in the RY 2008 final rule. To illustrate mathematically, if "base rate" is interpreted to mean "unadjusted rate," the "unadjusted rate" for RY 2008 ($38,086.04) would be the same as the RY 2007 "unadjusted rate" ($38,086.04). The RY 2008 "unadjusted rate" of $38,086.04 would subsequently be updated by the 0.71 percent update factor finalized in the RY 2008 final rule, resulting in a standard Federal rate for RY 2008 of $38,356.45, which is the same standard Federal rate that was originally finalized in the RY 2008 final rule. If we adopted this interpretation, we believe that LTCH PPS payments would be unaffected by section 114(e)(1) of MMSEA. Therefore, we believe that the term "base rate" used in section 114(e)(1) of MMSEA refers to the standard Federal rate. In subsequent sections of this preamble, we are using the term standard Federal rate instead of "base rate" when referencing the provision in section 114(e)(1) of MMSEA in order to avoid further confusion.

In the RY 2008 LTCH PPS final rule (72 FR 26890), we established a standard Federal rate of $38,356.45 for the 2008 LTCH PPS rate year that was based on the best available data and policies established in that final rule. As discussed above, section 114(e) of MMSEA revises the standard Federal rate for RY 2008 while specifying that this rate "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008" (that is, the first 9 months of RY 2008). Specifically, section 114(e)(1) of MMSEA provides that under the new section 1886(m)(2) of the Act, the standard Federal

rate for RY 2008 shall be the same as the standard Federal rate for RY 2007. The standard Federal rate for RY 2007 was $38,086.04 (71 FR 27818). Thus, to implement 114(e)(1) of the MMSEA, we are establishing through this interim final rule with comment period that the RY 2008 standard Federal rate is $38,086.04 (the same as the standard Federal rate for 2007). However, section 114(e)(2) of MMSEA specifically delays the application of the revised RY 2008 standard Federal rate. Specifically, section 114(e)(2) of MMSEA states that the revised RY 2008 standard Federal rate "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008." Therefore, LTCH payments for discharges occurring on or after July 1, 2007 through March 31, 2008, will continue to include an adjustment of 0.71 percent, that is, payments are based on the standard Federal rate in §412.523(c)(3)(iii)as updated by 0.71 percent. Accordingly, for discharges occurring on or after April 1, 2008 through June 30, 2008, the revised RY 2008 standard Federal rate of $38,086.04 is applied, while payments for discharges occurring from July 1, 2007 through March 31, 2008 are determined based on the standard Federal rate in §412.523(c)(3)(iii) increased by 0.71 percent that is, $38,356.45. We are revising §412.523(c)(iv) to conform to the revision of the standard Federal rate for RY 2008 under section 114(e) of MMSEA and to specify how payments are determined during RY 2008.

Furthermore, section 114(e) of MMSEA affects the high cost outlier fixed-loss amount currently in effect since it revises the standard Federal rate for RY 2008 and the standard Federal rate is used to determine the fixed-loss amount. Specifically, the current

fixed-loss amount was determined based on a standard Federal rate of $38,356.45. (See the RY 2008 LTCH PPS final rule (72 FR 26896 through 26899), as amended by the RY 2008 correction notice (72 FR 36613), for a discussion of the methodology and data used to determine the current fixed-loss amount for RY 2008.) Since for discharges occurring on or after April 1, 2008 through June 30, 2008, payments will be based on the revised RY 2008 standard Federal rate of $38,086.04, consistent with the existing regulations at §412.525(a), in order to maintain estimated total payments for high cost outlier cases at 8 percent of the estimated total payments, we are revising the high cost outlier fixed-loss amount. Accordingly, under the broad authority conferred on the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to make appropriate adjustments to the LTCH PPS, the revised high cost outlier fixed-loss amount effective for discharges occurring on or after April 1, 2008 through June 30 2008 is $20,707. This revised fixed-loss amount was determined using the same data and methodology presented in the RY 2008 LTCH PPS final rule and takes into account the revised RY 2008 standard Federal rate as provided for in the MMSEA (discussed above).

We note that in the RY 2009 LTCH PPS proposed rule (73 FR 5362), consistent with our historical practice, we proposed to update the standard Federal rate from the previous year (which is $38,086.04 due to section 114(e) of MMSEA, as explained above) to determine the proposed standard Federal rate for RY 2009.

III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking and invite public comment on a proposed rule in accordance with 5 U.S.C. section 553(b) of the Administrative Procedure Act (APA). In addition, section 1871(b)(1) provides that the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon. Section 1871(b)(2) provides for an exception to the requirement that the Secretary provide for notice of a proposed rulemaking and a period of not less than 60 days for public comment. Specifically, section 1871(b)(2)(B) of the Act provides an exception to these requirements when a law establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained. Here, various provisions of the MMSEA addressed in this interim final rule with comment period, changed existing LTCH PPS policies (it affected the short-stay outlier policy in §412.529 and revised the RY 2008 standard Federal rate. Such changes were required to be implemented: (1) beginning December 29, 2007 (section 114(c)(3)

of MMSEA and (2) were effective for RY 2008 on April 1, 2008 (section 114(e)(2) of MMSEA). Thus, the statute's deadline for implementation of the MMSEA-related policies contained in this interim final regulation was less than 150 days after the date of the enactment of the statute in which the deadline was contained. Therefore, under the authority of section 1871(b)(2)(B) of the Act, we are waiving notice and comment procedures for the MMSEA policy changes pertaining to the short-stay outlier policy, and the revised RY 2008 standard Federal rate.

Moreover, we also find good cause to waive the requirement for publication of a notice of proposed rulemaking and comment on the grounds that it is unnecessary, impracticable and contrary to the public interest under the authority of 5 U.S.C. 553(b)(B). In general, this interim final rule with comment period sets forth three nondiscretionary provisions of the MMSEA with respect to short-stay outliers and the rate for RY 2008. Therefore, we believe pursuing notice and comment is unnecessary. Moreover, because that process would prevent timely implementation of congressionally mandated policy changes that are to be effective, as described previously in this section, we believe notice and comment procedures are impracticable and contrary to the public interest. In addition, notice and comment would delay significantly the issuance of essential guidance to the public which is necessary to assist them in making complex, time-sensitive business decisions of significant financial consequence with respect to their efforts to comply with section 114 of the MMSEA. Failure to provide this guidance would impede such business decisions. This regulation also makes three

changes that are outside of the MMSEA mandated changes discussed above. Specifically, this regulation makes minor technical corrections to two incorrect cites that are embedded in §412.529 and it revises the fixed-loss amount for the period April 1, 2008 through June 30, 2008. With respect to the technical corrections of the two embedded cites in §412.529, notice and comment is also unnecessary. The revisions do not represent changes to our policy, and the public interest would, as a result, be best served by the timely correction of these technical errors. A delay in the applicability of the nonsubstantive changes would be contrary to the public interest because the incorrect cites, if left in place, result in confusion with respect to the calculation of cost to charge ratios. We also find good cause to waive notice and comment procedures on the revised fixed-loss amount for the period April 1, 2008 through June 30, 2008. The fixed-loss amount under the LTCH PPS is directly affected by to the statutorily mandated change to the standard Federal rate for RY 2008 cited above. The existing regulations limit estimated high cost outlier payments under the LTCH PPS to 8 percent of total estimated LTCH PPS payments. Accordingly, in order to assure that estimated high cost outlier payments are maintained at this 8 percent target, in conjunction with the Congressionally mandated change in the LTCH PPS payments (that is, the standard Federal rate) that applies April 1, 2008, it would be contrary to the public interest if we did not make this conforming change to the high cost outlier fixed-loss amount, which lowers the fixed-loss amount for the period April 1, 2008 through June 30, 2008.

Section 1871(e)(1)(A) of the Act provides that a substantive change in

regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change unless the Secretary determines that (i) such retroactive application is necessary to comply with statutory requirements; or (ii) failure to apply the change retroactively would be contrary to the public interest. As explained in the paragraph above, the MMSEA requires the Secretary to implement various policy changes contemporaneously with the enactment of the MMSEA on December 29, 2007. Therefore, under the authority of section 1871(e)(1)(A)(i) of the Act, we are making the provisions of this interim final rule with comment period that implement section 114(c)(3) of MMSEA retroactive to December 29, 2007. Additionally, as explained previously, Secretary also finds that it would be contrary to the public interest if these provisions were not made effective on December 29, 2007 as explained above.

Also, as explained in the previous paragraph, section 114(e)(1) of MMSEA requires the Secretary to revise standard Federal rate for RY 2008. However, the Secretary shall not apply such revised rate to discharges occurring on or after July 1, 2007 and before April 1, 2008 (section 114(e)(2) of the Act). Consequently, the regulations implementing section 114(e)(2) of MMSEA must be effective for a period predating this interim final rule with comment period under the authority of section 1871(e)(1)(A)(i) of the Act (specifically, beginning April 1, 2008). As explained previously, it would also be contrary to the public interest if these policies were not

effective April 1, 2008.

In general, many of the provisions of the MMSEA implemented in this interim final regulation are beneficial to LTCHs. If those MMSEA provisions of this regulation were not effective under the timeframes noted above, most LTCHs would be deprived the full benefit of these provisions. With respect to the minor technical corrections to §412.529, failure to make these nonsubstantive changes applicable beginning on December 29, 2007 would be contrary to the public interest because of the confusion that could result from the incorrect citations in §412.529. It is in the public interest to make the correction to prevent confusion among long-term care hospitals attempting to calculate cost-to-charge ratios. It is also contrary to the public interest as described above to not make the change to the fixed-loss amount applicable beginning April 1, 2008. Therefore, under the authority of section 1871(e)(1)(A)(ii) of the Act, we are making these changes effective under the timeframes noted above. For the same reasons note above, we find good cause under section 553(d)(3) of the APA to waive the 30-day delay in the effective date.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection

should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected .
- Recommendations to minimize the information collection burden on the affected public, and including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

Section 412.529(f)(4) states that for discharges occurring on or after October 1, 2006, short-stay outlier payments are subject to certain provisions. Specifically, §412.529(f)(4)(i) states that a hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio and this request must be approved by the appropriate CMS Regional Office.

The burden associated with this requirement is the time and effort necessary for a hospital to collect supporting evidence for submission, to draft the request for alternative cost-to-charge ratio, and to submit the request along with the supporting evidence to the appropriate CMS Regional Office. While this requirement is subject to the PRA, the burden is currently approved under OMB control number 0938-1020 with an expiration date of June 30, 2010.

TABLE 3: Estimated Annual Reporting and Recordkeeping Burden

Regulation Section(s)	OMB Control Number	Respondents	Responses	Burden Per Response (hours)	Total Annual Burden (hours)
§412.529(f)	0938-1020	18	18	8	144
Total					144

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Mail copies to the address specified in the ADDRESSES section of this proposed rule and to the

Office of Information and Regulatory Affairs,

Office of Management and Budget,

Room 10235, New Executive Office Building,

Washington, DC 20503,

Attn: Carolyn L. Raffaelli, CMS Desk Officer, CMS-1493-IFC,

Carolyn_L._Raffaelli@omb.eop.gov. Fax (202) 395-6974.

VI. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act,

the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804 (2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

As stated in section II.C. of this preamble, section 114(e)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 at the new 1886(m)(2) of the Act revises the standard Federal rate for RY 2008 by providing that "for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007" (in other words, the standard Federal rate for RY 2008 is the same as the standard Federal rate for 2007). Thus, the standard Federal rate for RY 2008 is established in section II.C. of this interim final rule with comment period at $38,086.04 (the same as the standard Federal rate for 2007). However, as we discussed in section II.D. of this interim final rule with comment period, section 114(e)(2) of the MMSEA specifically indicates that this rate "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008." Therefore, payments for discharges occurring on or after July 1, 2007 through March 31, 2008, are based on $38,356.45 (as

established in the RY 2008 LTCH PPS final rule), while for discharges occurring on or after April 1, 2008 through June 30, 2008, payments are based on the RY 2008 standard Federal rate which is $38,086.04. CMS' Office of the Actuary (OACT) estimates a projected decrease of approximately $5 million in estimated aggregate LTCH PPS payments for RY 2008 resulting from the change in payments for discharges occurring on or after April 1, 2008 through June 30, 2008. Additionally, as discussed in section II.B. of this interim final rule with comment period, section 114(c)(3) of MMSEA requires a 3-year suspension of our implementation of the revision to the SSO policy at §412.529(c)(3)(i) that was finalized in the RY 2008 final rule. OACT estimates that the SSO provision included in the MMSEA will result in a projected increase in estimated aggregate LTCH PPS payments for RY 2008 of $20 million. Consequently, we estimate the combined impact on estimated aggregate LTCH PPS payments for RY 2008 from the MMSEA provisions that are presented in this interim final rule with comment period to be approximately $15 million. Because the combined distributional effects and estimated changes to the Medicare program payments would not be greater than $100 million, this interim final rule with comment period would not be considered a major economic rule, as defined in this section.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having

revenues of $6.5 million to $31.5 million in any 1 year. (For further information, see the Small Business Administration's regulation at 70 FR 72577, December 6, 2005.) Individuals and States are not included in the definition of a small entity. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we assume that all LTCHs are considered small entities for the purpose of this impact discussion. Medicare FIs and MACs are not considered to be small entities. As we discuss in detail throughout the preamble of this interim final rule with comment period, we believe that the provisions specified by the MMSEA presented in this rule would result in an increase in estimated aggregate LTCH PPS payments. Accordingly, the Secretary certifies that this interim final rule with comment period would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. As stated above, implementing the provisions specified by the MMSEA that are discussed in this rule would result in an increase in estimated aggregate LTCH PPS payments; therefore, we believe this rule will not have a significant impact on small rural hospitals. Accordingly, the Secretary certifies that this

interim final rule with comment period would not have a significant economic impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2008, that threshold level is currently approximately $130 million. This interim final rule with comment period would not mandate any requirements for State, local, or tribal governments, nor would it result in expenditures by the private sector of $130 million or more in any 1 year.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements

For the reasons stated in the preamble of this interim final rule with comment period, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for Part 412 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In §412.1 paragraph (a)(4) is revised to read to as follows:

§ 412.1 Scope of part.

(a) * * *

(4) This part implements the following regarding long-term care hospitals--

(i) Section 123 of Public Law 106–113, which provides for the establishment of a prospective payment system for the costs of inpatient hospital services furnished to Medicare beneficiaries by long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act, for cost reporting periods beginning on or after October 1, 2002.

(ii) The provisions of section 307(b) of Public Law 106–554, which state that the Secretary shall examine and may provide for appropriate adjustments to the long-term care hospital prospective payment system, including adjustments to diagnosis-related group (DRG) weights, area wage adjustments, geographic reclassification, outlier

adjustments, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(iii) Section 114 of Public Law 110-173, which contains several provisions regarding long-term care hospitals, including the--

(A) Amendment of section 1886 of the Act to add a new subsection (m) that references section 123 of Public Law 106-113 and section 307(b) of Public Law 106-554 for the establishment and implementation of a prospective payment system for payments under title XVIII for inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Act.

(B) Revision of the standard Federal rate for RY 2008.

* * * * *

3. Section 412.500 is amended by revising paragraph (a) to read as follows:

§ 412.500 Basis and scope of subpart.

(a) Basis. This subpart implements the following:

(1) Section 123 of Public Law 106–113, which provides for the implementation of a prospective payment system for long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act.

(2) Section 307 of Public Law 106–554, which states that the Secretary shall examine and may provide for appropriate adjustments to that system, including adjustments to DRG weights, area wage adjustments, geographic reclassification,

outliers, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(3) Section 114 of Public Law 110-173, which contains several provisions regarding long-term care hospitals, including the--

(i) Amendment of section 1886 of the Act to add a new subsection (m) that references section 123 of Public Law 106-113 and section 307(b) of Public Law 106-554 for the establishment and implementation of a prospective payment system for payments under title XVIII for inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Act; and

(ii) Revision of the standard Federal rate for RY 2008

*** * * * ***

4. Section 412.523 is amended by revising paragraph (c)(3)(iv) to read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rates.

*** * * * ***

(c) * * *

(3) * * *

(iv) <u>For long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008</u>.

(A) The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008 is the same as the standard Federal rate for the previous long-term care hospital prospective payment system rate year. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after July 1, 2007 and before April 1, 2008, payments are based on the standard Federal rate in paragraph (c)(3)(iii) of this section updated by 0.71 percent.

*** * * * ***

5. Section 412.529 is amended by--

A. Revising paragraphs (c)(1) through (c)(3).

B. Redesignating paragraph (c)(4) as paragraph (f).

C. Revising newly redesignated paragraph (f).

§ 412.529 Special payment provision for short-stay outliers.

*** * * * ***

(c) * * *

(1) Discharges occurring before July 1, 2006. For discharges from long-term care hospitals described under §412.23(e)(2)(i), occurring before July 1, 2006, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) One hundred and twenty (120) percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section.

(ii) One hundred and twenty (120) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(iii) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

(2) Discharges occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2010. For discharges from long-term care hospitals described under §412.23(e)(2)(i) occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2010, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) One hundred and twenty (120) percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section.

(ii) One hundred (100) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(iii) The Federal prospective payment for the LTC–DRG as determined under paragraph (d)(3) of this section.

(iv) An amount payable under subpart O computed as a blend of an amount comparable to the hospital inpatient prospective payment system per diem amount

determined under paragraph (d)(4)(i) of this section and the 120 percent of the LTC-DRG specific per diem payment amount determined under paragraph (d)(1) of this section.

(A) The blend percentage applicable to the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the LTC–DRG or 25 days, not to exceed 100 percent.

(B) The blend percentage of the amount determined under paragraph (d)(4)(i) of this section is determined by subtracting the percentage determined in paragraph (A) from 100 percent.

(3) Discharges occurring on or after July 1, 2007 and before December 29, 2007 and discharges occurring on or after December 29, 2010. For discharges from long-term care hospitals described under §412.23(e)(2)(i) occurring on or after July 1, 2007 and before December 29, 2007 and discharges occurring on or after December 29, 2010, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is adjusted by either of the following:

(i) If the covered length of stay of the case assigned to a particular LTC–DRG is less than or equal to one standard deviation from the geometric ALOS of the same DRG under the inpatient prospective payment system (the IPPS-comparable threshold), the LTCH prospective payment system adjusted payment amount for such a case is the least of the following amounts:

(A) One hundred and twenty (120) percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section.

(B) One hundred (100) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(C) The Federal prospective payment for the LTC–DRG as determined under paragraph (d)(3) of this section.

(D) An amount payable under subpart O of this part comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4) of this section.

(ii) If the covered length of stay of the case assigned to a particular LTC–DRG is greater than one standard deviation from the geometric ALOS of the same DRG under the inpatient prospective payment system (the IPPS-comparable threshold), the LTCH prospective payment system adjusted payment amount for such a case is determined under paragraph (c)(2) of this section.

***** ***** ***** ***** *****

(f) Reconciliation of short-stay outlier payments. Payments are reconciled in accordance with one of the following:

(1) Discharges occurring on or after October 1, 2002, and before August 8, 2003. For discharges occurring on or after October 1, 2002, and before August 8, 2003, no reconciliations are made to short-stay outlier payments upon cost report settlement to

account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(2) Discharges occurring on or after August 8, 2003, and before October 1, 2006. For discharges occurring on or after August 8, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of §412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(3) Discharges occurring on or after October 1, 2003, and before October 1, 2006. For discharges occurring on or after October 1, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of §412.84(i)(2) for adjustments to cost-to-charge ratios.

(4) Discharges occurring on or after October 1, 2006. For discharges occurring on or after October 1, 2006, short-stay outlier payments are subject to the following provisions:

(i) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (f)(4)(ii) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. This request must be approved by the appropriate CMS Regional Office.

(ii) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(iii) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(A) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18 of this chapter.)

(B) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. CMS establishes and publishes this mean annually.

(C) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(iv) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(v) At the time of any reconciliation under paragraph (f)(4)(iv) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

CMS-1493-IFC

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: _____

_____

Kerry Weems,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: _____

_____

Michael O. Leavitt,

Secretary.

BILLING CODE 4120-01-P