DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, and 476

[CMS–1177–F]

RIN 0938–AK69

Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Implementation and FY 2003 Rates

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

ACTION: Final rule.

SUMMARY: This final rule establishes a prospective payment system for Medicare payment of inpatient hospital services furnished by long-term care hospitals (LTCHs) described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act). This final rule implements section 123 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 123 of the BBRA directs the Secretary to develop and implement a prospective payment system for LTCHs. The prospective payment system described in this final rule replaces the reasonable cost-based payment system under which LTCHs are currently paid.

EFFECTIVE DATE: The provisions of this final rule are effective on October 1, 2002.

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SUPPLEMENTARY INFORMATION:

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To assist readers in referencing sections contained in this preamble, we are providing the following table of contents.

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inaccurate computation of the relative weights for both DRGs.

Response: While the relative weights of 475 and 87 are not a coding issue, the hospital's method of reporting the codes has impacted DRG assignments and relative weights. The impact of how codes are reported is an issue that we did not anticipate when we computed the original relative weights. When providers submit multiple interim bills to us, only the diagnostic and procedural code data contained on the most recent bill are extracted for the MedPAR data file. When the DRG relative weights for the proposed rule were computed, they were based on the most recent MedPAR data. However, this data set contained some cases that apparently did not include all the codes that would have been present on the first billing. In one of the most striking examples, in those situations when the procedure code for ventilator use was not included on the bill, the DRG shifted from 475 to 87. As a result of this finding, we have reviewed the MedPAR file and recalibrated the relative weights based on the first data submitted to MedPAR. Relative weights in Table 3 in the Addendum to this final rule reflect our revised calculations.

Relative to correct coding practice for hospitals submitting interim bills, we have consulted with the members of the four Cooperating Parties (as discussed in section VIII.E.4. of this preamble) and have determined that correct coding practice includes the following concepts:

- The principal diagnosis will remain the same throughout the entire LTCH stay, and will be reported as the principal diagnosis on each claim submitted.
- Secondary or additional diagnoses will be coded as these conditions develop and will be reported on each claim submitted. For example, a LTCH patient develops a condition, such as decubiti, that was not present on admission. The code for this condition should be added to the next claim submitted, and will continue to be coded, even if the decubiti are successfully treated and ultimately resolved before the patient's discharge from the LTCH. If all appropriate secondary diagnoses, up to eight, are not present on the final claim, the DRG may not be correctly assigned. It is the responsibility of the LTCH to make sure their coding practices reflect proper coding on their claims.
- All procedures performed in the LTCH will be reported. This means that if a patient is on a ventilator at the beginning of his or her LTCH stay, or is placed on a ventilator during that stay, but is subsequently weaned from the ventilator, the ventilator code will continue to appear on all claims. This is true for the duration of that LTCH stay. Likewise, if a patient has another type of procedure such as 54.51 (Laparoscopic lysis of peritoneal adhesions), code 54.51 should continue to be reported on each claim submitted for the duration of the patient's stay at the LTCH.

The above guidelines are in place for short-term, acute care hospitals and assure accurate and consistent coding practice. LTCHs are to follow the coding guidelines for the acute care hospitals to ensure that same accuracy and consistency. There will be only one DRG assigned per long-term care hospitalization; it will be assigned at the discharge. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnostic codes that coexist at the time of admission, that subsequently develop, or that affect the treatment received. Similarly, all procedures performed during that stay are to be reported on each claim.

X. Payment System for LTCHs

In accordance with section 123(a)(1) of Public Law 106–113, we are using a discharge as the payment unit for the LTCH prospective payment system for Medicare patients. We will update the per discharge payment amounts annually. The payment rates encompass both inpatient operating and capital-related costs of furnishing covered inpatient LTCH services, including routine and ancillary costs, but not the costs of bad debts, approved educational activities, blood clotting factors, anesthesia services furnished by hospital-employed nonphysician anesthetists or obtained under arrangement, or the costs of photocopying and mailing medical records requested by a QIO, which are costs paid outside the prospective payment system. Generally, consistent with current policy under § 412.42, beneficiaries may be charged only for deductibles, coinsurance, and noncovered services (for example, telephone and television). In addition, beneficiaries may be charged for services furnished during a LTCH stay that are not covered under Medicare. They may not be charged for the differences between the hospital's cost of providing covered care and the Medicare LTCH prospective payment amount for the full LTC–DRG. (For further details, see section VIII.C. of this preamble.)

We determine the LTCH prospective payment rates using relative weights to account for the variation in resource use among LTC–DRGs. During FY 2003, the LTCH prospective payment system will be ''budget neutral'' in accordance with section 123(a)(1) of Public Law 106–113. That is, total payments for LTCHs during FY 2003 will be projected to equal payments that would have been paid for operating and capital-related costs of LTCHs had this new payment system not been enacted. Budget neutrality is discussed in detail in section X.J.2.h. of this preamble.

Based on our analysis of the data, we will make additional payments to LTCHs for discharges meeting specified criteria as high-cost ''outliers.'' Outliers are cases that have unusually high costs, exceeding the LTC–DRG payment plus the fixed loss amount, as discussed in section X.J.6. of this preamble. In addition to a high-cost outlier policy, we also are implementing payment policies regarding short-stay outliers and interrupted stays (sections X.C. and X.E. of this preamble).

In general, we are adopting the provisions for determining the prospective payments under the LTCH prospective payment system that we included in our March 22, 2002 proposed rule. If changes in this final rule have been made as a result of comments received, we discuss those changes in the context of the policy areas specified in this section of the preamble.

The LTCH prospective payment system uses Federal prospective payment rates across 499 distinct LTC–DRGs. We have established a standard Federal payment rate based on the best available LTCH cost data. LTC–DRG relative weights are applied to the standard Federal rate to account for the relative differences in resource use across the LTC–DRGs. As finalized in this final rule, the system also includes adjustments for short-stay outliers, differences in area wages (transitioned over 5 years), COLAs in Alaska and Hawaii, and high-cost outlier cases, as described in sections X.D., X.J.1., X.J.5., and X.J.6. of this preamble, respectively.

The standard Federal prospective payment rate, which is the basis for determining Federal payment rates for each LTC–DRG, is determined based on average costs from a base period, and also reflects the combined aggregate effects of the payment weights and other policies discussed in this section. In discussing the methodology, we begin by describing the various adjustments and factors that were considered in establishing the standard Federal prospective payment rate. We developed prospective payments for LTCHs using the following major steps:

We are revising the regulation text at § 412.533 to reflect this clarification.

In addition, it is now evident that the standard systems changes that are necessary to accommodate claims processing and payment under the new LTCH prospective payment system may not be in place by October 1, 2002. However, in order to comply with the statutory mandate to implement the LTCH prospective payment system no later than October 1, 2002, we are requiring that from October 1, 2002 until the systems changes are completed, all LTCHs, including those that elect to be paid based on 100 percent of the Federal rate, continue to submit their claims to and receive payment from their fiscal intermediaries as they otherwise would if the TEFRA payment system was still in effect. (We note that unless a LTCH that is required to comply with the HIPAA Administrative Simplification Standards obtains an extension in compliance with the Administrative Compliance Act, it must submit an electronic claim in compliance with 42 CFR 162.1002 and 42 CFR 1102 beginning October 16, 2002. Once the standard claims processing systems have been changed, the intermediary will ultimately reconcile any discrepancies between what LTCHs were paid and the payment amount determined under the LTCH prospective payment system. However, since the LTCH prospective payment system is in effect as of October 1, 2002, we would expect all bills submitted during this interim period to conform to the coding and billing guidelines as described in section VIII.H. of this preamble.

In proposed § 412.535, we proposed a schedule for publishing information on the LTCH prospective payment system for each fiscal year in the **Federal Register**, prior to the start of each fiscal year, on or before August 1. This cycle coincides with the statutorily mandated publication schedule for the inpatient acute care prospective payment system. Section 1886(e)(5) of the Act requires that for the acute care prospective payment system, the proposed rule be published in the **Federal Register** not later than ''the April 1 before each fiscal year''; and the final rule, not later than ''the August 1 before such fiscal year.'' The Act imposes no such requirement for the LTCH prospective payment system. Therefore, to avoid concurrent publications for these two systems, for purposes of administrative feasibility and efficiency, we will be considering a change in the schedule for updating the LTCH prospective payment system to be effective July 1 of each year. We will address this issue in the future.

O. Payments to New LTCHs

In the March 22, 2002 proposed rule, for the purposes of defining a new LTCH, we proposed under § 412.23(e)(4) to define a new LTCH as a provider of inpatient hospital services that (1) meets the revised qualifying classification criteria (described in section VIII.B. of this preamble and in § 412.23(e)(1)); and (2) under present or previous ownership (or both), has not received payment as a LTCH for discharges prior to October 1, 2002 (the effective date of the prospective payment system for LTCHs). We also proposed in § 412.500 that the LTCH prospective payment system applies to hospitals with a cost reporting period beginning on or after October 1, 2002.

We believe that these two statements are inconsistent because proposed § 412.23(e)(4) ties the status of a LTCH (that is, existing or new) to whether or not the hospital has received payment as a LTCH prior to the effective date of the LTCH prospective payment system, as opposed to focusing on whether the hospitals first cost reporting period begins on or after October 1, 2002 (the effective date of the statute). We believe the most appropriate focus in the instant case should be linked to the statute's emphasis of cost reporting periods beginning on or after October 1, 2002. In this final rule, we are revising the regulation so that the definition of a new LTCH more closely mirrors the statutory provision. Accordingly, for purposes of Medicare payment under the prospective payment system, we are defining a new LTCH as a provider of inpatient hospital services that otherwise meets the qualifying criteria for LTCHs, set forth in § 412.23(e)(1) and (e)(2) and, under present or previous ownership (or both), and its first cost reporting period as a LTCH begins on or after October 1, 2002. We are revising § 412.23(e)(4) to reflect this correction.

As noted above, new LTCHs will not participate in the 5-year transition from cost-based reimbursement to prospective payment (see section X.N. of this preamble). The transition period described in section X.N. of this preamble is intended to provide existing LTCHs time to adjust to payment under the new system. Since these new LTCHs with cost reporting periods beginning on or after October 1, 2002 would not have received payment under TEFRA for the delivery of LTCH services prior to the effective date of the LTCH prospective payment system, we do not believe that those new LTCHs require a transition period in order to make adjustments to their operations and capital financing, as will LTCHs that have been paid under TEFRA.

This definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, described in section 1886(b)(7)(A) of the Act, added by section 4416 of Public Law 105–33. As stated in § 413.40(f)(2)(ii), for cost reporting periods beginning on or after October 1, 1997, the payment amount for a ''new'' (post-FY 1998) LTCH is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median target amount payment limit for hospitals in the same class for cost reporting periods ending during FY 1996, updated to the applicable cost reporting period (see 62 FR 46019, August 29, 1997). Under the prospective payment system for LTCHs, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have first cost reporting periods prior to October 1, 2002 will be paid under the transition methodology described in section X.N. of this preamble.

For example, a ''new'' LTCH (post-FY 1998) that first began receiving payment as a LTCH on October 1, 2001, will be subject to the 110 percent of the median target amount payment limit for LTCHs (in accordance with § 413.40(f)(2)(ii)) for both its FY 2002 (October 1, 2001 through September 30, 2002) and FY 2003 (October 1, 2002 through September 30, 2003) cost reporting periods. Assuming the hospital has not elected to be paid 100 percent of the Federal rate for its cost reporting period beginning on October 1, 2002 (the first cost reporting period when the LTCH will be subject to the prospective payment system), the hospital would be paid under the transition methodology whereby the LTCH's TEFRA portion of its payment for operating costs (80 percent) is limited by the 110 percent of the median target amount payment limit for LTCHs under § 413.40(f)(2)(ii). For its cost reporting period beginning on October 1, 2003 (which is the hospital's third cost reporting period), under the transition methodology, that LTCH's TEFRA portion of its payment for operating costs (60 percent) will be limited to its target amount as determined under § 413.40(c)(4)(v). Furthermore, if a hospital is designated as a LTCH on September 1, 2002, it would not be considered a new LTCH under § 412.23(e)(4), even if it had not discharged any patients or received any payments as of the implementation date of the LTCH prospective payment system on October 1, 2002, because its first cost reporting period didn't begin

on or after October 1, 2002. Thus, it would be paid according to § 413.40(f)(2)(ii) from September 1, 2002 through August 30, 2003. This LTCH would not be subject to payments under the LTCH prospective payment system until the start of its next cost reporting period on September 1, 2003. At the beginning of its second cost reporting period as a LTCH (that is, September 1, 2003), this LTCH would be subject to the transition period in § 412.533(a)(1), because this provision applies to cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003. Under the blended payments of the transition period in § 412.533(a)(1), 80 percent of payments for operating costs would be paid under the TEFRA system, as described in § 413.40(f)(2)(ii). (This hospital could also elect to be paid 100 percent of the Federal rate for its cost reporting period beginning September 1, 2003.) We did not receive any comments on this proposal.

P. Method of Payment

As discussed earlier, a Medicare patient will be classified into a LTC–DRG based on the principal diagnosis, up to eight additional (secondary) diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The LTC–DRG will be used to determine the Federal prospective payment that the LTCH will receive for the Medicare-covered Part A services the LTCH furnished during the Medicare patient's stay. Under § 412.541(a), the payment is based on the submission of the discharge bill since section 123(a) of Public Law 106–113 requires that the LTCH prospective payment system be a per discharge based system. The discharge bill provides data to allow for reclassifying the stay from payment at the full LTC–DRG rate to payment for a case as a short-stay outlier (under § 412.529) or as a interrupted stay (under § 412.531), or to determine if the case will qualify for a high-cost outlier payment (under § 412.525(a)).

Accordingly, the ICD–9–CM codes and other information used to determine if an adjustment to the full LTC–DRG payment is necessary (for example, length of stay or interrupted stay status) is recorded by the LTCH on the Medicare patient's discharge bill and submitted to the Medicare fiscal intermediary for processing. The payment made represents payment in full, under § 412.521(b), for inpatient operating and capital-related costs, but not the costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists or obtained under arrangement, or the costs of photocopying and mailing medical records requested by a QIO, which are costs paid outside the LTCH prospective payment system. We note that in this final rule, under § 412.521(b)(2)(i), we have added a reference to § 413.87 to indicate that payments for Medicare+Choice nursing and allied health education costs are made separate from payments under the LTCH prospective payment system.

Under the current payment system, a LTCH may elect to be paid using the periodic interim payment (PIP) method described in § 413.64(h), and may be eligible to receive accelerated payments as described in § 413.64(g). As we discussed in the proposed rule, with the implementation of a prospective payment system for LTCHs, we will continue to allow the PIPs method of payment as provided for under § 413.64(h) and accelerated payments as provided for under § 413.64(g) for qualified LTCHs.

We are adopting, as final, the proposed provisions for the methods of payment available to LTCHs. In addition, based on a commenter's concern, we wish to clarify a provision that for those LTCHs that choose not to elect to receive payments under the PIP method or that are not qualified to receive payment under the PIP method may continue to bill on an interim basis. Consistent with the interim payment provision under acute care hospital inpatient prospective payment system we are including a new subsection (d) at § 412.541 stating that LTCHs with unusually long lengths of stay, not receiving payment under the PIP method may bill on an interim basis. Consistent with the interim payment provisions under the acute care hospital inpatient prospective payment system at § 412.116(d), we believe that to allow those LTCHs experiencing unusually long stays to receive interim payments 60 days after an admission and every 60 days thereafter would help to alleviate any financial hardship that could result otherwise. We believe that this is both a fair and equitable solution. We are also including some technical changes to the language under § 413.64 to correct regulations citations to reflect the availability of the PIP method for LTCHs under the prospective payment systems.

For those LTCHs that are paid during the 5-year transition based on the blended transition methodology in § 412.533 for cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006, the PIP amount is based on the transition blend. For those LTCHs that are paid based on 100 percent of the standard Federal rate, the PIP amount is based on the estimated prospective payment for the year rather than on the estimated cost reimbursement. In this final rule, as in the proposed rule, we are clarifying that we are excluding outlier payments that are paid upon submission of a discharge bill from the PIP amounts. In addition, in this final rule, as in the proposed rule, Part A costs that are not paid for under the LTCH prospective payment system, including Medicare costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists or obtained under arrangement, and the costs of photocopying and mailing medical records requested by a QIO is subject to the interim payment provisions.

Comment: Several commenters explained that LTCHs could experience financing difficulties because of the potentially lengthy period between the time a LTCH incurs costs to provide care and the date on which it receives payment following claims submission. One commenter stated that their provider bills on a cyclical basis, thus, allowing for more prompt receipt of payment from Medicare and more timely billing of deductibles and coinsurance to second insurers. Another commenter pointed out that some LTCHs do not qualify for the PIP method of payment. The commenter asked whether LTCHs that are currently receiving interim payments may switch to the PIP method. The commenter recommended that in order to avoid the heavy financial burden for LTCHs, these hospitals should be allowed to obtain interim payments similar to the method currently available to cost-based providers under the present regulations. In addition, some commenters expressed concern that Medicare fiscal intermediaries may not have the most current data upon which to base interim payments while others had questions regarding the timeliness and accuracy of the process used to determine PIP payments.

Response: As we stated above, we are revising the current regulations at § 412.541 to include a subsection (d) that allows LTCHs that are not receiving payments under the PIP method and that are experiencing unusually long stays to bill 60 days after an admission and every 60 days thereafter. Existing § 412.116(d) permits special interim payments for ''unusually long lengths of stay'' that it further describes as ''after a Medicare beneficiary has been in the hospital at least 60 days.'' LTCHs that

patient's principal diagnosis), regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. The LTC–DRG classification system provides a LTC–DRG, and an appropriate weighting factor, for those cases for which none of the surgical procedures performed are related to the principal diagnosis.

(c) *Review of LTC–DRG assignment.*

(1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a LTC–DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews that hospital's request and any additional information and decides whether a change in the LTC–DRG assignment is appropriate. If the intermediary decides that a different LTC–DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 476.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (c)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

§ 412.515 LTC–DRG weighting factors.

For each LTC–DRG, CMS assigns an appropriate weight that reflects the estimated relative cost of hospital resources used within that group compared to discharges classified within other groups.

§ 412.517 Revision of LTC-DRG group classifications and weighting factors.

CMS adjusts the classifications and weighting factors annually to reflect changes in—

(a) Treatment patterns;

(b) Technology;

(c) Number of discharges; and

(d) Other factors affecting the relative use of hospital resources.

§ 412.521 Basis of payment.

(a) *Method of payment.*

(1) Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate established in accordance with § 412.523, including adjustments described in § 412.525, and, if applicable during a transition period, on a blend of the Federal payment rate and the cost-based reimbursement rate described in § 412.533.

(b) *Payment in full.*

(1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance described in subpart G of part 409 of this subchapter) for covered inpatient operating costs as described in § 412.2(c) and capital-related costs described in subpart G of part 413 of this subchapter associated with furnishing Medicare covered services in long-term care hospitals.

(2) In addition to payment based on prospective payment rates, long-term care hospitals may receive payments separate from payments under the prospective payment system for the following:

(i) The costs of approved medical education programs described in §§ 413.85, 413.86, and 413.87 of this subchapter.

(ii) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this subchapter.

(iii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(iv) Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements, as specified in § 412.113(c)(2).

(v) The costs of photocopying and mailing medical records requested by a QIO, in accordance with § 476.78(c) of this chapter.

(c) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan that is primary to Medicare pays in full or in part, payment is determined in accordance with the guidelines specified in § 412.120(b).

(d) *Effect of change of ownership on payments under the prospective payment system.* When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(1) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments as provided in § 412.525 and payments for hemophilia clotting factor costs as provided in paragraph (b)(2)(iii) of this section, are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Other payments for the direct costs of approved medical education programs, bad debts, anesthesia services furnished by hospital employed nonphysician anesthetists, and costs of photocopying and mailing medical records to the QIO as provided for under paragraphs (b)(2)(i), (ii), (iv), and (v) of this section are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

§ 412.523 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the initial prospective payment rates for inpatient hospital services furnished by long-term care hospitals, CMS uses—

(1) The best Medicare data available; and

(2) A rate of increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient long-term care hospital services.

(b) *Determining the average costs per discharge for FY 2003.* CMS determines the average inpatient operating and capital-related costs per discharge for which payment is made to each inpatient long-term care hospital using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to FY 2003 by a rate of increase factor, described in paragraph (a)(2) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(c) *Determining the Federal prospective payment rates.*

(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard Federal rate. The standard Federal rate is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor

then admitted, all prior discharges are considered, even if the discharge occurs late in one cost reporting period and the readmission occurs late in next cost reporting period.

(i) A long-term care hospital or a satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days following the effective date of these regulations and within 60 days of a change in this co-located status.

§ 412.533 Transition payments.

(a) *Duration of transition periods.* Except for a long-term care hospital that makes an election under paragraph (c) of this section or for a long-term care hospital that is defined as new under § 412.23(e)(4), for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, a long-term care hospital receives a payment comprised of a blend of the adjusted Federal prospective payment as determined under § 412.523, and the payment determined under the cost-based reimbursement rules under Part 413 of this subchapter.

(1) For cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003, payment is based on 20 percent of the Federal prospective payment rate and 80 percent of the cost-based reimbursement rate.

(2) For cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004, payment is based on 40 percent of the Federal prospective payment rate and 60 percent of the cost-based reimbursement rate.

(3) For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005, payment is based on 60 percent of the Federal prospective payment rate and 40 percent of the cost-based reimbursement rate.

(4) For cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006, payment is based on 80 percent of the Federal prospective payment rate and 20 percent of the cost-based reimbursement rate.

(5) For cost reporting periods beginning on or after October 1, 2006, payment is based entirely on the adjusted Federal prospective payment rate.

(b) *Adjustments based on reconciliation of cost reports.* The cost-based percentage of the provider's total Medicare payment under paragraphs (a)(1) through (a)(4) of this section are subject to adjustments based on reconciliation of cost reports.

(c) *Election not to be paid under the transition period methodology.* A long-term care hospital may elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition periods specified in paragraph (a) of this section. Once a long-term care hospital elects to be paid based on 100 percent of the Federal prospective payment rate, it may not revert to the transition blend.

(1) *General requirement.* A long-term care hospital must notify its fiscal intermediary of its intent to elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period specified in paragraph (a) of this section.

(2) *Notification requirement to make election.*

(i) The request by the long-term care hospital to make the election under paragraph (c)(1) of this section must be made in writing to the Medicare fiscal intermediary.

(ii) For cost reporting periods that begin on or after October 1, 2002 through November 30, 2002, the fiscal intermediary must receive the notification of the election before November 1, 2002.

(iii) For cost reporting periods that begin on or after December 1, 2002 through September 30, 2006, the fiscal intermediary must receive the notification of the election on or before the 30th day before the applicable cost reporting period begins.

(iv) The fiscal intermediary must receive the notification by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section will not be accepted. If the date specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section falls on a day that the postal service or other delivery sources are not open for business, the long-term care hospital is responsible for allowing sufficient time for the delivery of the notification before the deadline.

(v) If a long-term care hospital's notification is not received by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, payment will be based on the transition period rates specified in paragraphs (a)(1) through (a)(5) of this section.

(d) *Payments to new long-term care hospitals.* A new long-term care hospital, as defined in § 412.23(e)(4), will be paid based on 100 percent of the standard Federal rate, as described in § 412.523, with no transition payments, as described in § 412.533(a)(1) through (a)(5).

§ 412.535 Publication of the Federal prospective payment rates.

CMS publishes information pertaining to the long-term care hospital prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the LTC–DRG classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.541 Method of payment under the long-term care hospital prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, long-term care hospitals receive payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.*

(1) *Criteria for receiving periodic interim payments.*

(i) A long-term care hospital receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the long-term care hospital must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) As provided in § 413.64(h)(5) of this subchapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of the PIP resulting in an overpayment to the provider.

(2) *Frequency of payment.*

(i) For long-term care hospitals approved for PIP and paid solely under Federal prospective payment system rates under § 412.533(b), the intermediary estimates the long-term care hospital's Federal prospective payments net after estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year.

(ii) For long-term care hospitals approved for PIP and paid using the blended payment schedule specified in § 412.533(a) for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, the intermediary estimates the hospital's portion of the Federal prospective payments net and the hospital's portion of the reasonable cost-based reimbursement payments net, after beneficiary deductibles and coinsurance, in accordance with the blended transition percentages specified in § 412.533(a), and makes biweekly payments equal to 1/26 of the total estimated amount of both portions of payments for the year.

(iii) If the long-term care hospital has payment experience under the long-term care hospital prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year.

(iv) Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter.

(v) The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the hospital.* Subject to paragraph (b)(1)(iii) of this section, a long-term care hospital receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the long-term care hospital no longer meets the requirements of § 413.64(h) of this subchapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for the costs of an approved education program, blood clotting factors, anesthesia services furnished by hospital-employed nonphysician anesthetists or obtained under arrangement, and photocopying and mailing medical records to a QIO, which are costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a long-term care hospital receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Special interim payment for unusually long lengths of stay.*

(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment 60 days after a Medicare beneficiary has been admitted to the hospital. Payment for the interim bill is determined as if the bill were a final discharge bill.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph.

(e) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(f) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to a long-term care hospital that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the long-term care hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A request by a long-term care hospital for an accelerated payment must be approved by the intermediary and by CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as long-term care hospital bills are processed or by direct payment by the long-term care hospital.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

2. Section 413.1 is amended by:

a. Revising paragraph (d)(2)(ii).

b. Adding paragraphs (d)(2)(vi) and (d)(2)(vii).

§ 413.1 Introduction.

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's and psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals) that are excluded from the prospective payment systems under subpart B of Part 412 of this subchapter and hospitals outside the 50 states and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 413.40.

* * * * *

(vi) For cost reporting periods beginning before October 1, 2002, payment to long-term care hospitals that are excluded under subpart B of Part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of § 413.40.

(vii) For cost reporting periods beginning on or after October 1, 2002, payment to the long-term hospitals that meet the condition for payment of §§ 412.505 through 412.511 of this subchapter is based on prospectively determined rates under subpart O of Part 412 of this subchapter.

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Subpart C—Limits on Cost Reimbursement

3. Section 413.40 is amended by:

a. Republishing the introductory text of paragraph (a)(2)(i).

b. Adding a new paragraph (a)(2)(i)(D).

c. Amending paragraph (a)(2)(ii) by republishing the introductory text, removing ''and'' at the end of paragraph (a)(2)(ii)(A), removing the period and