DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1493–IFC2]

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 Moratorium on the Establishment of New Long-Term Care Hospitals and Long-Term Care Hospital Satellite Facilities and Increases in Beds in Existing Long-Term Care Hospitals and Long-Term Care Hospital Satellite Facilities; and 3-Year Delay in the Application of Certain Payment Adjustments

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) and LTCH satellite facilities. It implements a 3-year moratorium on the establishment of new LTCHs and LTCH satellite facilities; and on increases in beds in existing LTCHs and LTCH satellite facilities. This interim final rule with comment period also implements a 3-year delay in the application of certain payment policies which apply payment adjustments for discharges from LTCHs and LTCH satellites that were admitted from certain referring hospitals in excess of various percentage thresholds.

DATES: *Effective date:* The provisions of this interim final rule with comment period 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 this interim final rule with comment period is necessary to comply with the statute and that failure to apply the changes retroactively would be contrary to public interest.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 21, 2008.

ADDRESSES: In commenting, please refer to file code CMS–1493–IFC2. 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–IFC2, 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–IFC2, 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 Judy Richter, (410) 786–2590, Moratorium and 25 percent patient threshold adjustment.

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).

The most recent annual update to the LTCH PPS was presented in the RY 2009 LTCH PPS final rule (73 FR 26788). In that final rule, among other things, we established a 2.7 percent update to the Federal rate for RY 2009, and presented other payment rate and policy changes, including revising the rate year to a year beginning October 1 and ending on September 30. (The 2009 rate year will begin on July 1, 2008 and end on September 30, 2009).

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. Two 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 as a LTCH, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient LOS of greater than 25 days. Alternatively, to be classified as a LTCH, a hospital must have a provider agreement with Medicare and meet the average LOS requirement in § 412.23(e)(2)(ii). Section 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 meets the LOS criteria if it has an average inpatient LOS for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days, and can also 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.

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. The fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) verify that LTCHs meet the average LOS requirements. (For a more detailed explanation, see the June 6, 2003 final rule (68 FR 34123).)

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 implements the following provisions affecting LTCH PPS payments:

- Modification of payment adjustments to LTCHs and LTCH satellite discharges that were admitted from specific referring hospitals and that exceed various percentage thresholds. Sections 114(c)(1) and (2) of MMSEA mandates specific changes for 3 years, beginning with cost reporting periods beginning on or after December 29, 2007, with respect to existing § 412.534, which governs the ''25 percent threshold'' payment adjustment to LTCH hospitals-within-hospitals (HwHs) and LTCH satellite facilities for discharges that were admitted from their co-located hosts (established in the FY 2005 IPPS final rule and amended in the RY 2008 LTCH PPS final rule), and existing § 412.536, which applies a payment adjustment policy (that was in transition to 25 percent prior to the enactment of this law) to LTCH and LTCH satellite facility discharges that were admitted from any individual hospital not co-located with the LTCH or LTCH satellite facility (established in the RY 2008 LTCH PPS final rule), as discussed in section II.B. of this interim final rule with comment period.
- *Moratorium on new LTCHs, LTCH satellite facilities, and increase in beds in existing LTCHs and LTCH satellite facilities.* Section 114(d) of MMSEA established a 3-year moratorium beginning on December 29, 2007 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 of MMSEA made other changes affecting LTCH PPS payments. The following is a listing of the other rulemaking documents published and respective provisions of section 114 of MMSEA that were implemented:

- In the May 1, 2008 interim final rule with comment period (73 FR 24871)—

++ *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 (see § 412.529(c)(3)(i)) 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) as revised in the RY 2008 LTCH PPS final rule shall not apply for a 3-year 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.

• In the January 29, 2008 proposed rule and May 9, 2008 final rule 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).

We also note that section 114 of MMSEA included additional provisions focusing on LTCHs but are not directly related to payment policy. The following is a list of those policies which are not included in this interim final rule with comment period:

• 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. Payment Adjustment to LTCHs and LTCH Satellite Facilities

The enactment of section 114(c) of MMSEA requires several modifications to payment provisions applicable to various types of LTCHs under the regulations at § 412.534 and § 412.536. (Throughout this section, ''LTCH'' or ''LTCH satellite facility'' refers exclusively to ''subclause (I)'' LTCHs and LTCH satellite facilities, that is, LTCHs defined by section 1886(d)(1)(B)(iv)(I) of the Act. This is the case because the policies established at § 412.534 and § 412.536 do not apply to a ''subclause (II)'' LTCH defined under section 1886(d)(1)(B)(iv)(II) (69 FR 49205 and 72 FR 26924). Currently, § 412.534 provides for a payment adjustment for a co-located LTCH (HwH or satellite), based upon the percentage of the HwH's or satellite's Medicare discharges that had been admitted from a hospital with which it is co-located (typically, an acute care hospital).

As specified in the RY 2008 LTCH PPS final rule (72 FR 26870), § 412.534 also applies to a ''grandfathered'' LTCH HwH or LTCH satellite facility, that is not required to meet the ''separateness and control'' policies at § 412.22(e) or (h)(2)(iii), respectively, regarding its relationship to the hospital with which it is co-located (see 72 FR 26926 through 26928). In the RY 2008 LTCH PPS final rule, we also established, at § 412.536, an adjustment based on the percentage of Medicare discharges that had been admitted to a LTCH or LTCH satellite facility, from an individual referring hospital with which the LTCH or LTCH satellite facility is not co-located. When we extended the policy in § 412.534 to grandfathered LTCH HwHs and LTCH satellite facilities in the RY 2008 LTCH PPS final rule, we provided for a parallel 3-year transition to the full percentage threshold for cost reporting periods beginning on or after July 1, 2007 at § 412.534(h) for ''grandfathered'' LTCHs and LTCH satellite facilities discharging patients admitted from their host hospitals and at § 412.536(f) for discharges that were admitted to a LTCH or LTCH satellite facility from any referring hospital with which they were not co-located (72 FR 26944).

In this interim final rule with comment period, we are revising our regulations at § 412.534 and § 412.536 to implement the requirements of sections 114(c)(1) and 114(c)(2) of MMSEA. Specifically, for cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010, section 114(c)(1) of MMSEA generally exempts ''freestanding'' LTCHs (that is, as newly defined in § 412.23(e)(5), a LTCH that meets the requirements at § 412.23(e)(1) and (2), and does not occupy space in a building also used by another hospital or does not occupy space in one or more separate or entire buildings located on the same campus as buildings used by another hospital, and is not part of a hospital that provides inpatient services in a building also used by another hospital and ''grandfathered'' LTCH HwHs (that is, ''a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33)'') from the applicable percentage threshold policy established at § 412.536. The statutory provision also exempts grandfathered HwHs from the applicable percentage threshold at § 412.534(h). Accordingly, for cost reporting periods beginning on or after December 29, 2007, for a 3-year period, the adjustments at § 412.536 will not apply to ''freestanding'' LTCHs and the adjustments at § 412.534 and § 412.536 will not apply to ''grandfathered'' LTCH HwHs. Furthermore, the legislation prohibits the application of ''any similar provisions'' to either ''freestanding'' LTCHs or to ''grandfathered'' LTCH HwHs for that same 3-year period. Section 114(c)(2) of MMSEA also revises the current percentage thresholds at § 412.534 for applicable LTCHs HwHs and LTCH satellite facilities. We are providing two tables to illustrate the statutory and regulatory changes for LTCHs and LTCHs satellite facilities associated with the implementation of section 114(c)(1) and (2) of MMSEA. Table 1 indicates the applicability of the specific provisions of section 114(c)(1) and (2) of MMSEA by type of LTCH or LTCH satellite facility. Table 2, indicates the applicability of § 412.534 and § 412.536 by type of LTCH or LTCH satellite facility.

TABLE 1.—APPLICABILITY OF SECTION 114(C)(1) AND (2) OF MMSEA BY LTCH TYPE

LTCH type	Applicability of			
	Section 114(c)(1)(A) of MMSEA	Section 114(c)(1)(B) of MMSEA	Section 114(c)(2)(A) of MMSEA	Section 114(c)(2)(B) of MMSEA
Freestanding LTCHs	Yes	N/A	N/A	N/A.
Grandfathered HwHs (under section 4417(a) of the BBA § 412.22(f))[1]	N/A	Yes	N/A	N/A.
Nongrandfathered HwHs Subject to Transition at § 412.534(g)[2]	N/A	N/A	Yes	Yes.
Nongrandfathered HwHs *not* Subject to Transition at § 412.534(g)[3]	N/A	N/A	N/A	N/A.
Grandfathered LTCH Satellites (§ 412.22(h)(3)(i))[4]	N/A	N/A	N/A	N/A.
Nongrandfathered LTCH Satellites Subject to Transition at § 412.534(g)[5]	N/A	N/A	Yes	Yes.
Nongrandfathered LTCH Satellites *not* Subject to Transition at § 412.534(g)[6].	N/A	N/A	N/A	N/A.

[1] These are LTCH HwHs that were not required to meet the ''separateness and control'' policies at § 412.22(e) and were so classified by the Secretary on or before September 30, 1995.

[2] These are LTCH HwHs subject to the separateness and control policies at § 412.22(e) that were paid under the LTCH PPS as of October 1, 2004 or an LTCH HwH paid under the LTCH PPS as of October 1, 2005 whose qualifying period began on or before October 1, 2004.

[3] These are LTCH HwHs subject to the separateness and control policies at § 412.22(e) *not* paid under the LTCH PPS as of October 1, 2004, or October 1, 2005 with a qualifying period that began on or before October 1, 2004.

[4] These are LTCH satellites not subject to the separateness and control policies at§ 412.22(h)(2)(iii) and that were structured as satellite facilities on September 30, 1999 and excluded from the IPPS on that date.

[5] These are LTCH satellites subject to the separateness and control policies at § 412.22(h)(2)(iii) that were paid under the LTCH PPS as of October 1, 2004.

[6] These are LTCH satellites subject to the separateness and control policies at § 412.22(h)(2)(iii) that were *not* paid under the LTCH PPS as of October 1, 2004.

TABLE 2.—REVISIONS TO § 412.534 AND § 412.536 OF THE REGULATIONS IN ACCORDANCE WITH SECTION 114(C)(1) AND (2) OF MMSEA BY LTCH TYPE

LTCH type*	Applicability of	
	§ 412.534	§ 412.536
Freestanding (as described § 412.23(e)(5) of the regulations).	N/A	3-year delay for cost reporting periods beginning on or after 12/29/2007 and before 12/29/2010. (Section 114(c)(1)(A) of MMSEA).
Nongrandfathered HwH (as described § 412.23(e)(2)(i) that meet the criteria in § 412.22(e)).	(1) If subject to the transition at § 412.534(g) (including those located in rural areas or co-located with an MSA-dominant hospital or urban-single hospital), applicable but with *revised* thresholds. (2) If not subject to the transition at § 412.534(g) (including those located in rural areas or co-located with an MSA-dominant hospital or urban-single hospital), § 412.534 is applicable with *no change* in thresholds.	No change. Applicable subject to existing transition at § 412.536(f).
Grandfathered HwH (as described in section 4417(a) of the BBA and described in § 412.23(e)(2)(i) and meets the criteria of § 412.22(f) of the regulations).	3-year delay for cost reporting periods beginning on or after 12/29/2007 and before 12/29/2010 (as specified in section 114(c)(1)(B) of MMSEA.	3-year delay for cost reporting periods beginning on or after 12/29/2007 and before 12/29/2010 (as specified in section 114(c)(1)(B) of MMSEA).
Nongrandfathered LTCH Satellite Facility (as described in § 412.23(e)(2)(i) and meets the criteria of § 412.22(h) of the regulations).	(1) If subject to the transition in § 412.534(g) (including those located in rural areas or co-located with an MSA-dominant hospital or urban-single hospital), is applicable but with *revised* thresholds. (2) If not subject to the transition in § 412.534(g) (including those located in rural areas or co-located with an MSA-dominant hospital or urban-single hospital), is applicable with *no change* in thresholds.	No change—Applicable Subject to existing transition at § 412.536(f).
Grandfathered LTCH Satellite Facility (as described in § 412.23(e)(2)(i) that meets the criteria § 412.22(h)(3)(i)).	Applicable—subject to transition at § 412.534(h).	No change. Applicable subject to existing transition at § 412.536(f).

* Neither § 412.534 or § 412.536 apply to a section 1886(d)(1)(B)(iv)(II) of the Act ''subclause (II)'' LTCH or LTCH satellite facility.

For purposes of the requirements of section 114(c) of MMSEA, the distinction between a freestanding LTCH and a LTCH that is co-located as either an HwH or a LTCH satellite facility is significant. A ''freestanding'' LTCH is a LTCH which is not co-located with another hospital-level provider as either a HwH, defined at § 412.22(e), or as a satellite of a hospital as defined at § 412.22(h)(1). A HwH is defined at § 412.22(e) as ''* * * a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital * * *'' At § 412.22(f) we describe ''grandfathered'' HwHs which meet the definition at § 412.22(e) but are exempt from the ''separateness and control'' policies at § 412.22(e)(1). The term ''satellite facilities'' defined at § 412.22(h) which addresses satellites of hospitals; is ''* * * a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital * * *'' For purposes of the HwH regulations at § 412.22(e) and the satellite regulations at § 412.22(h), we utilize the definition of ''campus'' in the provider-based regulations at § 413.65(a)(2). Section 413.65 defines a campus as ''the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual basis, by the CMS regional office, to be part of the provider's campus.''

Section 114(c) of MMSEA employs the term ''freestanding'' in identifying one group of LTCHs which the provision exempted from the 25 percent patient threshold adjustment for 3 years. The statute did not define the term freestanding LTCHs in section 114(c)(1)(A) of MMSEA which pertains to the adjustment policy in § 412.536 or any similar provision. In order to minimize confusion and ensure the MMSEA is implemented consistently, we are adding a definition for freestanding LTCH to our regulations at § 412.23(e)(5). The definition is consistent with our application of the concept under § 412.534 and § 412.536. For purposes of section 114(c) of

MMSEA, therefore, we are establishing a regulatory definition of a ''freestanding LTCH'' at § 412.23(e)(5), as a hospital that meets the requirements of § 412.23(e)(1) and (2) that does not occupy space in a building also used by another hospital, or in one or more separate or entire buildings located on the same campus as buildings used by another hospital or is not part of a hospital that provides inpatient services in a building also used by another hospital.

As noted above, section 114(c)(1)(B) of MMSEA specifies a 3-year delay, effective with cost reporting periods beginning on or after the date of enactment of MMSEA (that is, December 29, 2007), in the application of ''such section, or § 412.534 of title 42, Code of Federal Regulations, or any similar provisions to a long-term care hospital identified by the amendment made by section 4417(a) of the Balance Budget Act (BBA) of 1997 (Pub. L. 105–33).'' We believe that the phrase ''such section'' refers to § 412.536 because this provision is the main topic of the preceding subparagraph (A). We further believe that the inclusion of the phrase ''or any similar provisions'' after specifying § 412.534, in section 114(c)(1)(B) of MMSEA exempts ''grandfathered'' LTCHs from any regulatory scheme which would apply a percentage patient payment adjustment similar to that in § 412.534 or § 412.536 for a 3-year period. As noted above, the type of LTCH identified by section 4417(a) of the BBA is limited to a ''grandfathered'' LTCH HwH. Section 4417(a) of the BBA (which amended section 1886(d)(1)(B) of the Act) specifies that ''[a] hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.'' (Section 1886(d)(1)(B)(iv) of the Act sets forth the definition of LTCHs.) Section 4417(a) of BBA effectively exempted this particular group of LTCH HwHs from the ''separateness and control'' policies at § 412.22(e)(2) which govern the relationship between a HwH and the hospital with which it is co-located. These ''grandfathered'' LTCHs are allowed to maintain their IPPS-exclusions so long as they continue to comply with applicable Medicare requirements. As noted above, section 114(c)(1)(B) of MMSEA provides that the Secretary shall not apply the percentage thresholds established at § 412.536 and § 412.534 (or any similar provisions) for a 3-year period, for cost reporting periods beginning on or after the date of enactment, December 29, 2007, to ''grandfathered'' LTCH HwHs. Section 114(c)(1)(A) of MMSEA also specifies that the Secretary shall not apply the provisions at § 412.536 (or any similar provision) to ''freestanding'' LTCHs for the 3-year period for cost-reporting periods beginning on or after December 29, 2007. However, it is important to note that both ''grandfathered'' LTCH HwHs and ''freestanding'' LTCHs for cost reporting periods beginning *before* December 29, 2007, *remain* subject to the applicable payment adjustments specified in § 412.534(h) and § 412.536, for that particular cost reporting period. Section 412.534(h), with respect to ''grandfathered'' LTCHs, and § 412.536 with respect to all LTCHs were implemented for cost-reporting period beginning on or after July 1, 2007. The policy modifications mandated by section 114(c) of MMSEA are effective'' * * * for cost reporting periods beginning on or after the date of enactment of this Act for a 3-year period.'' Therefore, a ''grandfathered'' or a ''freestanding'' LTCH with a cost reporting period that begins on or after July 1, 2007 but before December 29, 2007, would be subject to the provisions of § 412.534 and § 412.536, as appropriate, until the start of its next cost reporting period. For example, for a LTCH with a cost reporting period beginning on July 1, 2007, the changes required by section 114(c) of MMSEA would only apply beginning on or after July 1, 2008. The 3 years of relief available to such a facility would continue until the end of its cost reporting period that began before December 29, 2010 (that is, the LTCH's last cost reporting period affected by this provision would begin July 1, 2010 and end June 30, 2011). In another example, for a LTCH that had a September 1 through August 31 cost reporting period, the first cost reporting period for which it would be granted the relief specified in section 114(c) of MMSEA, would be its cost reporting period beginning on September 1, 2008 and the last cost reporting period would be the period beginning on September 1, 2010 and ending on August 31, 2011.

Although section 114(c)(1) of MMSEA exempts ''grandfathered'' LTCH HwHs from the ''25 percent patient threshold payment adjustment'' at § 412.534 and § 412.536, a ''grandfathered'' satellite of a LTCH, under § 412.22(h)(3) continues to be subject to the applicable percentage thresholds outlined in § 412.536 for patients admitted from any individual hospital with which it is not co-located because there are no exceptions under the MMSEA for such entities for purposes of § 412.536. Also, grandfathered LTCH satellites continue to be subject to the applicable existing percentage thresholds in § 412.534(h) for patients admitted from their co-located hospital because there are no exceptions for these entities under the MMSEA for purposes of § 412.534. The existing transitions to the full payment adjustments for ''grandfathered'' LTCH satellites at § 412.534(h)(2) also continue to apply. The revision to the percentages made by section 114(c)(2) of MMSEA were limited to a hospital a LTCH satellite subject to the transition rules at § 412.534(g). Grandfathered LTCH satellites are subject to the transition at § 412.534(h), not to those at § 412.534(g). Specifically, in the case of a satellite of a LTCH that is described under paragraph (h)(1), the thresholds applied at (c), (d), and (e) will not be less than the percentage specific below:

- For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008 a threshold of the lesser of 75 percent of the total number of Medicare discharges that were admitted to the LTCH satellite facility from its co-located hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the LTCH satellite facility from that co-located hospital during the satellite's RY 2005 cost reporting period.
- For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, we use the formula in the paragraph above except that we substitute 50 percent for 75 percent; and
- For cost reporting periods beginning on or after July 1, 2009, the 25 percent adjustment is applied.

Similarly, the transition to the full 25 percent threshold or applicable threshold provided at § 412.536(f) continues to be applicable for discharges that were admitted to a nongrandfathered HwH or a nongrandfathered LTCH satellite facility or grandfathered satellite facility from any hospital with which the HwH or LTCH satellite facility is not co-located, because section 114(c)(1) of MMSEA provides no exceptions for such entities. This transition at § 412.536 parallels the transition at § 412.534(h)(2).

With respect to LTCH HwHs and LTCH satellite facilities that are not grandfathered, the applicable percentage thresholds established at § 412.536, continue to apply because the MMSEA provides no exceptions for such entities. In addition, nongrandfathered HwHs and both grandfathered and nongrandfatered LTCH satellite facilities continue to be subject to § 412.534.

However, to the extent a nongrandfathered LTCH HwH or LTCH satellite facility meets the definition of an ''applicable long-term care hospital or satellite facility,'' the *revised* percentage thresholds in section 114(c)(2)(A) and (B)(i) of MMSEA apply for cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010.

Specifically, section 114(c)(2)(B)(i) of MMSEA of 2007 modifies the percentage thresholds specified in existing § 412.534(c) from 25 percent to 50 percent for ''an applicable'' LTCH HwH or LTCH satellite facility described below, for 3 years, for cost reporting periods beginning on or after December 29, 2007. Therefore, payment to an applicable LTCH or LTCH satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under § 412.534 if no more than 50 percent of the hospital's Medicare discharges during the hospital's fiscal year (other than discharges described in § 412.534(c)(3)) are admitted from the co-located hospital. (We note that § 412.534(c)(3) expressly excludes patients who had achieved high cost outlier status at the discharging co-located hospital.) Section 114(c)(2)(B)(ii) of MMSEA defines ''an applicable long-term care hospital or satellite facility'' as ''* * * a hospital or satellite facility that is subject to the transition rules under § 412.534(g) * * *'' The transition rules in § 412.534(g) apply to LTCH HwH and satellites that had been paid under the LTCH PPS as of October 1, 2004 or a LTCH HwH that is paid under the LTCH PPS on October 1, 2005 whose qualifying period under § 412.23(e) began on or before October 1, 2004 (see 69 FR 49206). Accordingly, an applicable LTCH HwH and LTCH satellite facility for purposes of section 114(c)(2)(ii) of the MMSEA is ''* * * a long-term care hospital or a satellite facility that is paid under the provisions of subpart O on October 1, 2004 or of a hospital that is paid under the provisions of subpart O and whose qualifying period under § 412.23(e) began on or before October 1, 2004 * * *'' (§ 412.534(g)). (For a more detailed explanation, see the FY 2005 IPPS final rule.)

Therefore, if a nongrandfathered LTCH or LTCH satellite facility does not meet the definition of an ''applicable long-term care hospital or satellite facility'', the thresholds established under existing § 412.534 are not modified by section 114(c)(2) of MMSEA.

The revised thresholds under section 114(c)(2)(A) of MMSEA for ''applicable'' LTCH HwHs and LTCH satellite facilities are as follows: The provision raises the existing 50 percent ceiling on percentage thresholds for ''applicable'' LTCH HwHs or LTCH satellite facilities that are located either in rural areas or that are co-located with an urban single or metropolitan statistical area (MSA-dominant) hospital (under § 412.534 (d)(1), (e)(1), and (e)(4) of the regulations) to 75 percent. (We note that § 412.534(d)(2) and (e)(3), which expressly excludes patients who had achieved high cost outlier status at the discharging co-located hospital prior to admission to the LTCH or LTCH satellite from being counted towards the threshold has not been modified.) In other words, payment to an applicable LTCH or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under § 412.534(d)(1), (e)(1), and (e)(4) is not subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in § 412.534(d)(2) or (e)(3)) are admitted from a co-located hospital. Section 114(c)(2) of MMSEA also raises the existing 25 percent patient threshold payment adjustment to ''applicable'' LTCH HwHs and LTCH satellites, defined previously, from 25 percent to 50 percent. Furthermore, we would also emphasize that since this modification only applies to ''applicable'' LTCHs and LTCH satellites, as defined in paragraph section 114(c)(2)(B)(ii) of MMSEA, those LTCH HwHs and LTCH satellites that were not subject to the transition policy set forth at § 412.534(g), will continue to have the existing patient percentage threshold applied.

In accordance with the transition policy specified at § 412.534(g), for cost reporting periods beginning on or after October 1, 2007, the percentage threshold even for ''applicable'' LTCH HwHs and LTCH satellite facilities decreased from 50 percent to 25 percent for LTCH HwHs and LTCH satellite facilities and the thresholds for rural, MSA-dominant, and urban single LTCHs and LTCH satellite facilities were held at 50 percent (see § 412.534(d) and (e)). Since the percentage threshold modifications established under section 114(c)(2) of MMSEA are implemented for cost reporting periods beginning on or after December 29, 2007, if an ''applicable'' LTCH HwH and LTCH satellite had a cost reporting period beginning before that date (specifically, a cost reporting period beginning on or after October 1, 2007 and before December 29, 2007), the facility would be subject to the 25 percent threshold that was in effect at the start of that cost reporting period or a 50 percent threshold if the facility was located in a rural area or is co-located with an MSA-dominant or urban single hospital. However, for 3 years, beginning with the ''applicable'' HwH's or LTCH satellite's first cost reporting period beginning on or after December 29, 2007 the percentage thresholds increase to 50 percent and for an ''applicable'' LTCH HwHs and satellites located in a rural area, or co-located with an MSA-dominant, or urban single hospital for that 3-year period, the 50 percent threshold increases to 75 percent.

In compliance with section 114(c) of MMSEA, we have revised § 412.534 and § 412.536 to implement the 3-year delay in the application of the percentage patient threshold payment adjustment to ''freestanding and grandfathered LTCHs'' and the 3-year revision in the percentage payment thresholds adjustments for ''applicable'' LTCHs and satellite facilities. We have also made technical corrections to § 412.534(b) in order to clarify the effective dates of the percentage patient threshold policy for discharges from a LTCH HwH or from a LTCH satellite that were admitted from the hospital with which it is co-located.

B. Moratorium on the Establishment of Long-Term Care Hospitals, Long-Term Care Hospital Satellite Facilities, and on the Increase in Number of Beds in Existing Long-Term Care Hospitals or Long-Term Care Hospital Satellite Facilities

1. Overview

Section 114(d) of MMSEA provides a 3-year moratorium with two distinct aspects, one for the establishment of new LTCHs and LTCH satellite facilities, and the other for the increase of hospital beds in existing LTCHs and LTCH satellite facilities. Specifically, section 114(d)(1)(A) of MMSEA provides that the Secretary shall impose a moratorium ''subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility.'' Section 114 (d)(1)(B) of MMSEA provides that, the Secretary shall impose a moratorium ''subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.''

Sections 114(d)(2) and (d)(3) of MMSEA provide for exceptions to the moratorium imposed by section 114(d)(1) of MMSEA. It is important to

note that the two categories of exceptions are mutually exclusive. The three exceptions specified in section 114(d)(2) of MMSEA, discussed below, are only applicable to the moratorium provision at section 114(d)(1)(A) of MMSEA, which applies exclusively to the establishment and classification of a LTCH or LTCH satellite facility. The three exceptions in section 114(d)(2) do not apply to the moratorium on an increase in beds at section 114(d)(1)(B) of MMSEA. Similarly, the exception at section 114(d)(3)(A) of MMSEA only applies to the moratorium on increases in beds at existing LTCHs or LTCH satellites facilities, and not to the moratorium on the establishment of LTCHs and LTCH satellite facilities.

2. Analysis of Exceptions to the Moratorium on the Establishment of New LTCHs and LTCH Satellite Facilities

In section 114(d)(1)(A) of MMSEA, the statute specifically provides for a 3-year moratorium effective on the date of enactment of the MMSEA on the establishment and classification of a long-term care hospital or satellite facility, other than an existing LTCH or facility. (The term ''existing,'' with respect to a hospital or satellite facility, is defined in the legislation at section 114(d)(4) of MMSEA as ''a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.'') The MMSEA was enacted on December 29, 2007. Therefore, the moratorium will be effective from December 29, 2007 through December 28, 2010. Section 114(d)(2) of MMSEA specifies that the moratorium on the establishment and classification of a LTCH or LTCH satellite facility does not apply to a LTCH that, as of December 29, 2007, met one of the following three exceptions:

- The LTCH began ''its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal regulations, on or before the date of enactment of this Act'' (section 114(d)(2)(A)).
- The LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a LTCH and has expended before December 29, 2007 at least 10 percent of the estimated cost of the project or, if less, $2,500,000 (section 114(d)(2)(B)).
- The LTCH has obtained an approved certificate of need in a State where one is required on or before December 29, 2007 (section 114(d)(2)(C)).

In implementing the provisions of section 114(d) of MMSEA, we found that, in light of the unique nature of LTCHs as a category of Medicare provider, some of the terminology in the provision is internally inconsistent. Therefore, we were required to interpret the provisions in the way we believe reasonably reconciles seemingly inconsistent provisions and that results in an application of the provisions that is logical and workable. We discuss our interpretations below.

Specifically, section 114(d)(1)(A) of MMSEA indicates that the moratorium on the establishment and classification of a LTCH or satellite facility, other than an existing LTCH or satellite facility, is ''subject to paragraph (2).'' In contrast paragraph (2) is titled, ''Exception for Certain Long-Term Care Hospitals'' and it begins with ''[t]he moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act.'' We note that the term ''satellite'' is omitted in paragraph (2) even though satellites are entities subject to the moratorium provision. Because section 114(d)(1)(A) of MMSEA appears to contemplate an exception to the moratorium for both qualifying LTCHs and qualifying satellite facilities, we believe that it is appropriate to apply paragraph (2) to new LTCH satellite facilities just as it applies to LTCHs. Our interpretation of the statute is premised on this presumption.

An additional problem with paragraph (2) of section 114(d) of MMSEA is that a strictly literal reading of the statutory language in that paragraph presents practical challenges for implementation in light of the established LTCH classification criteria in section 412.23(e).

Below, we examine the exceptions to the moratorium on the establishment and classification of a long-term care hospital or satellite facility in light of the classification criteria for LTCHs at § 412.23(e) and the presumption that the provision allows, where practicable in limited situations, a new LTCH satellite facility to qualify for an exception under section 114(d)(2) of MMSEA. The first exception in section 114(d)(2)(A) of MMSEA applies to ''a long-term care hospital that as of the date of the enactment of this Act* * * began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act.'' We believe this exception regarding the qualifying period refers to the period established in our regulations at § 412.23(e)(3) during which the predecessor hospital is collecting LOS data to be used to demonstrate that the hospital meets the LOS requirements (explained in more detail below) to be classified as a LTCH. Specifically in order for a hospital to be designated as a LTCH, the LTCH classification criteria regulations at § 412.23(e) stipulate the following:

(e) *Long-term care hospitals.* A long-term care hospital must meet the requirements of paragraph (e)(1) and (e)(2) of this section and, when applicable, the additional requirement of § 412.22(e), to be excluded from the prospective payment system specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(4) and in Subpart O of this part.

(1) *Provider agreements.* The hospital must have a provider agreement under Part 489 of this chapter to participate as a hospital; and

(2) *Average length of stay.* (i) The hospital must have an average Medicare inpatient length of stay of greater than 25 days; * * *

As provided by § 412.23(e)(1), the qualifying period for a ''new'' or ''planned'' LTCH may not begin before the facility has obtained a provider agreement, under 42 CFR part 489, to participate in the Medicare program as a hospital. Typically, when a new hospital is established, after operating as a hospital, such a facility could present patient LOS data from a short (6 months) cost report using data from at least 5 months of the 6-month period immediately preceding the start of the cost reporting period for which the hospital is seeking LTCH designation.

In light of how we view the qualifying period under section 412.23(e), we note that it is not possible for a LTCH, as of the date of enactment of MMSEA, to begin its qualifying period as a LTCH. Technically, under the LTCH classification criteria regulations at 412.23(e), it is an existing hospital, not a LTCH, that has a qualifying period for LTCH status. Therefore, we believe that the exception specified at section 114(c)(2)(A) of MMSEA applies to an existing hospital that began its qualifying period on or before December 29, 2007 for LTCH status. To qualify for the exception to the moratorium, the LOS data used to demonstrate that the hospital has an average LOS greater than 25 days must be from its cost reporting period that began on or before December 29, 2007. In addition, we note that the exception at section 114(d)(2)(A) of MMSEA would not be applicable to satellite facilities since there is no ''qualifying period'' for the establishment of a satellite facility for payment as a LTCH under § 412.23(e).

Next, under section 114(d)(2)(B) of MMSEA, an exception to the

moratorium is made for a long-term care hospital that, as of the date of the enactment of the MMSEA (December 29, 2007), satisfies the two prongs of the exception: (1) it has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital; and (2) It has expended, before the date of enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000). As drafted, this provision is problematic in light of § 412.23(e). For example, where a hospital has not even been built, but there is a binding written agreement for the actual construction of a hospital that intends to be classified as a LTCH, technically it is not a LTCH that is party to the binding written agreement. In such a situation, no LTCH would yet exist. Prior to the existence of a LTCH, a hospital must first be established, certified, and complete the procedures specified in § 412.23(e) in order to qualify as a LTCH, at which point the hospital would be classified as a LTCH.

In light of the LTCH classification criteria in § 412.23(e), and our presumption that new LTCH satellite facilities are included in the exceptions in section 114(d)(2) of MMSEA, the exception in section 114(d)(2)(B) of MMSEA applies in the following three circumstances: (1) As of the date of enactment of the MMSEA, an existing hospital (that is, one that was certified as a hospital as of December 29, 2007) that will become an LTCH has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease, or demolition for converting the hospital to a LTCH and has expended, before December 29, 2007, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); (2) as of the date of enactment of the MMSEA, an entity that will develop a hospital that will ultimately become a LTCH has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease, or demolition for a hospital and that entity has expended, before December 29, 2007, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); and (3) an existing LTCH, as of December 29, 2007, has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease or demolition for a new LTCH satellite facility and the LTCH has expended before December 29, 2007 at least 10 percent of the estimated cost of the project (or, if less, $2,500,000).

With regard to the first prong, we believe that the use of the term ''actual'' in the context of the ''actual construction, renovation, lease, or demolition,'' indicates that the the provision focuses only on the specific accomplishments cited in the statute and does not include those that are contemplated or have not yet been executed. Although we are aware that a hospital or entity may enter into binding written agreements regarding services and items (for example, feasibility studies or land purchase) and incur costs for those services and items prior to actual construction, renovation, lease or demolition, we believe those services or items are not included in the statute as a basis for the exception.

With respect to the second prong, the statute specifies that the hospital or entity must have expended before December 29, 2007, at least 10 percent of the estimated cost of the project (or, if less, $2.5 million). By ''cost of the project,'' we believe the statute refers to the activities enumerated in the first prong: ''The actual construction, renovation, lease, or demolition for a long-term care hospital.'' The statute requires that the hospital or entity has spent the amount specified in the statute on the actual construction, renovation, lease, or demolition for the contemplated LTCH. Furthermore, because the statute uses the phrase ''has expended'' we believe that the statute requires that hospital or entity would have actually transferred funds as payment for the project as opposed to merely obligating capital and posting the cost of the project on its books as of December 29, 2007. We believe that the provision addressed the concept of ''obligate'' in the first prong of the test where the statute specifies ''a binding written agreement * * * for the actual construction, renovation, lease, or demolition of the long-term care hospital. . .'' and there is no reason to believe that the second prong of the test, which requires the ''expenditure'' of 10 percent of the project or if less, $2,500,000, was intended as a redundancy. The ability to post the expense on the hospital's or entity's books could be satisfied by merely having a binding written agreement under the first prong of section 114(d)(2)(B) of MMSEA. The fact that a second requirement is included that involves an expenditure indicates that an additional threshold must be met.

Finally, section 114(d)(2)(C) of MMSEA provides an exception for a long-term care hospital that, as of the date of the enactment of the Act, ''has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.'' We do not believe that the provision limits the exception to only an existing long-term care hospital that has obtained an approved certificate of need to create a new satellite of the LTCH. We note that in many instances, prior to being classified as a LTCH, a hospital is to be built by an entity with the express intention of making it into a LTCH as soon as possible. In those instances, it is not uncommon for the entity to obtain a certificate of need from the State prior to the development of the hospital.

We believe that the certificate of need exception applies to a hospital or entity that was actively engaged in developing a LTCH, as evidenced by the fact that either an entity that wanted to create a LTCH but did not exist as a hospital as of December 29, 2007, had obtained a certificate of need for a hospital by the date of enactment, or an existing hospital had obtained a certificate of need to convert the hospital into a new LTCH by that date. However, this exception would not apply to a hospital that was already in existence prior to the date of enactment and that had previously obtained an approved certificate of need for a hospital (other than a LTCH) on or before December 29, 2007. The fact that a hospital may have had a certificate of need issued to it years before December 29, 2007, to operate a hospital (other than a LTCH) would not be a reason to grant it an exception, unless that certificate of need was specifically for a LTCH. Since the certificate of need process is controlled at the State level, in determining whether the hospital or entity has obtained an approved certificate of need on or before December 29, 2007, we will look to the State for that determination.

2. Analysis of Exception to the Moratorium on the Increase in Number of Long-Term Care Hospital Beds in Existing Long-Term Care Hospitals and Satellite Facilities

In section 114(d)(1)(B) of MMSEA, a moratorium is also imposed on existing LTCHs or LTCH satellite facilities for the 3-year period beginning December 29, 2007 through December 28, 2010. The moratorium is on an increase of LTCH beds in existing LTCHs or LTCH satellite facilities. Therefore, during the 3-year moratorium, an existing LTCH or LTCH satellite facility may not increase the number of beds in excess of the number of Medicare-certified beds at the hospital on December 29, 2007. We are using the number of beds certified by Medicare, because this number can be verified by CMS and its contractors and this is currently referenced in our

regulations at § 412.22(h)(2)(i), and similarly referenced in § 412.22(f)(1). The moratorium on an increase of beds is subject to the exception at section 114(d)(3) of MMSEA. Specifically, section 114(d)(3) of the MMSEA states that the moratorium on an increase in beds shall not apply if an existing LTCH or LTCH satellite facility is ''located in a State where there is only one other long-term care hospital; and requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.'' Section 114 (d)(3)(B) of the MMSEA also provides that the exception to the moratorium on the increase in bed numbers for existing LTCHs or LTCH satellite facilities does not apply to the limit on the number of beds in ''grandfathered'' LTCH HwHs as specified at § 412.22(f) and LTCH satellite facilities as specified at § 412.22(h)(3). Under § 412.22(f) and § 412.22(h)(3), respectively, ''grandfathered'' LTCH HwHs and LTCH satellite facilities (that is, HwHs that were in existence on or before September 30, 1995 and LTCH satellite facilities that were in existence on or before September 30, 1999 and that meet certain specified conditions) are exempted from compliance with ''separateness and control'' policies as long as they do not increase their bed numbers. (See the FY 2007 IPPS final rule (71 FR 48106 through 48115).) Therefore, even if a ''grandfathered'' LTCH HwH or LTCH satellite facility is located in a State where there is only one other LTCH and it requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State, it would not be able to maintain its grandfathered status if it would increase the number of beds at the LTCH under this exception.

Decisions regarding whether a specific situation will be considered to meet the exceptions to the establishment and classification of new LTCHs or new LTCH satellite facilities or the exceptions on increasing the number of beds in existing LTCHs or LTCH satellite facilities will be determined on a case-by-case basis by the applicant's FI/MAC and the CMS Regional Office (RO).

In compliance with section 114(d) of MMSEA, we are revising our regulations at § 412.23 to include a description of the moratorium on the establishment of new LTCHs and LTCH satellites and the moratorium on increasing the number of beds in existing LTCHs and existing LTCH satellites. Additionally, in § 412.23(e)(5) we have established a definition of a freestanding LTCH.

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. 553(b) of the Administrative Procedure Act (APA). In addition, section 1871(b)(1) of the Act 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) of the Act 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. Several provisions of the MMSEA changed existing LTCH PPS policies (it affected the adjustment policies in § 412.534 and § 412.536; and placed a moratorium on new LTCHs and LTCH satellite facilities, as well as a moratorium on bed increases in existing LTCHs and LTCH satellite facilities). These changes were required to be implemented: (1) Beginning December 29, 2007 (section 114(d) of MMSEA); or (2) beginning with cost reporting periods beginning on or after December 29, 2007 (section 114(c)(1) and (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. We also note that we established a definition of ''freestanding LTCH'' at § 412.23(e)(5) consistent with our application of § 412.534 and § 412.536 in order to ensure consistent implementation of section 114(c)(1) of the MMSEA. 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 § 412.534 and § 412.536 (including the addition of the definition of freestanding LTCH at § 412.23(e)(5)) as well as the moratorium on new LTCHs and LTCH satellite facilities, and the moratorium on increasing beds at an existing LTCH and an existing satellite facility of a LTCH.

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 nondiscretionary provisions of the MMSEA with respect to a moratorium on the establishment of new long-term care hospitals and long-term care satellite facilities and on the increase of long-term care hospital beds in existing LTCHs or LTCH satellite facilities, and payment policies pertaining to § 412.534 and § 412.536. 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.

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 either contemporaneously with the enactment of the MMSEA on December 29, 2007 or beginning with cost reporting periods beginning on or after December 29, 2007 as applicable. 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 sections 114(d) of MMSEA retroactive to December 29, 2007. The statute also requires that section 114(c)(1) and (2) be implemented beginning with cost reporting periods beginning on or after 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)(1) and (2) effective for cost reporting periods beginning on or after December 29, 2007. Additionally, as explained previously, the Secretary also finds that it would be contrary to the public interest if these provisions were not made effective on December 29, 2007 or for cost reporting periods beginning on or after December 29, 2007, as indicated above. Therefore, under the authority of section 1871(e)(1)(A)(ii) of the Act, we are making these changes effective under the timeframe noted above.

For the same reasons noted above, we find good cause under section 553(d)(3) of the APA to waive the 30-day delay in effective date.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

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).

The enactment of section 114(c) of MMSEA requires several modifications to the regulations at § 412.534 and § 412.536, which, as discussed in section II.A of this interim final rule with comment period, address the percentage thresholds between referring hospitals (typically acute care hospitals) and LTCHs and satellites of LTCHs. We estimate that the implementation of MMSEA provisions pertaining to § 412.534 and § 412.536 will result in a projected increase of approximately $30 million in estimated aggregate LTCH PPS payments for RY 2008. We note that at this time, we are unable to quantify the impact of the provision at section 114(d) of MMSEA which provides for a moratorium on the establishment of LTCHs, LTCH satellite facilities, and on the increase of LTCH beds in existing LTCHs or satellite facilities for a period of 3 years. We are unable to provide an estimate of the impact of the moratorium provisions in section II.B. of this interim final rule with comment period because we have no way of determining how many LTCHs would have opened in the absence of the moratorium, nor do we have sufficient information at this time to determine how many new LTCHs will meet the exceptions criteria provided for in the statute. Because the 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 interim final rule with comment period will 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 in 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. Section 412.23 is amended by adding new paragraphs (e)(5) through (e)(7) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) * * *

(5) *Freestanding long-term care hospital.* For purposes of this paragraph, a freestanding long-term care hospital means a hospital that meets the requirements of paragraph (e)(1) and (2) of this section and all of the following:

(i) Does not occupy space in a building also used by another hospital.

(ii) Does not occupy space in one or more separate or entire buildings located on the same campus as buildings used by another hospital.

(iii) Is not part of a hospital that provides inpatient services in a building also used by another hospital.

(6) *Moratorium on the establishment of new long-term care hospitals and long-term care hospital satellite facilities.*

(i) *General rule.* Except as specified in paragraph (e)(6)(ii) of this paragraph, for the period beginning December 29, 2007 and ending December 28, 2010, a moratorium applies to the establishment and classification of a long-term care hospital or long-term care hospital satellite facility as described in § 412.23(e).

(ii) *Exception.* The moratorium specified in paragraph (e)(6)(i) of this section is not applicable to the establishment and classification of a long-term care hospital that meets the requirements in paragraph (e) of this section or a long-term care hospital satellite facility that meets the requirements in § 412.22(h), if the long-term care hospital met one of the following criteria on or before December 29, 2007:

(A) Began its qualifying period for payment in accordance with paragraph (e) of this section.

(B)(*1*) Has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease or demolition for a long-term care hospital; and

(*2*) Has expended, before December 29, 2007, at least 10 percent (or, if less, $2.5 million) of the estimated cost of the project specified in paragraph (ii)(B)(1) of this paragraph.

(C) Had obtained an approved certificate of need from the State, when required by State law.

(7) *Moratorium on increasing the number of beds in existing long-term care hospitals and existing long-term care hospital satellite facilities.*

(i) For purposes of this paragraph, an existing long-term care hospital or long-term care hospital satellite facility means a long-term care hospital that meets the requirements of paragraph (e) of this section or long-term care hospital satellite facility that meets the requirements of § 412.22(h) of this part and received payment under the provisions of subpart O of this part on or before December 29, 2007.

(ii) Effective for the period beginning December 29, 2007 and ending December 28, 2010—

(A) Except as specified in paragraph (e)(7)(ii)(B) of this section, the number of Medicare-certified beds in an existing long-term care hospital or an existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section must not be increased beyond the number of Medicare-certified beds on December 29, 2007.

(B) Except as specified in paragraph (e)(7)(ii)(C) of this section, the moratorium specified in paragraph (e)(7)(ii)(A) of this section is not applicable to an existing long-term care hospital or existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section that meets both of the following requirements:

(*1*) Is located in a State where there is only one other long-term care hospital that meets the criteria specified in § 412.23(e) of this subpart.

(*2*) Requests an increase in the number of Medicare-certified beds after the closure or decrease in the number of Medicare-certified beds of another long-term care hospital in the State.

(C) The exception specified in paragraph (e)(7)(ii)(B) of this section does not effect the limitation on increasing beds under § 412.22(f) and § 412.22(h)(3) of subpart.

* * * * *

■ 4. Section 412.534 is amended by revising paragraphs (b) through (e), and (h) to read as follows.

§ 412.534 Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals.

* * * * *

(b) *Patients admitted from hospitals not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite.*

(1) *For cost reporting periods beginning on or after October 1, 2004 and before July 1, 2007.* Payments to the long-term care hospital as described in § 412.23(e)(2)(i) meeting the criteria in § 412.22(e)(2) for patients admitted to the long-term care hospital or to a long-term care hospital satellite facility as described in § 412.23(e)(2)(i) that meets the criteria of § 412.22(h) from another hospital that is not the co-located hospital are made under the rules in this subpart with no adjustment under this section.

(2) *For cost reporting periods beginning on or after July 1, 2007.* For cost reporting periods beginning on or after July 1, 2007, payments to one of the following long-term care hospitals or long-term care hospital satellites are subject to the provisions of § 412.536 of this subpart:

(i) A long-term care hospital as described in § 412.23(e)(2)(i) of this part that meets the criteria of § 412.22(e) of this part.

(ii) Except as provided in paragraph (h) of this section, a long-term care hospital as described in § 412.23(e)(2)(i) of this part that meets the criteria of § 412.22(f) of this part.

(iii) A long-term care hospital satellite facility as described in § 412.23(e)(2)(i) of this part that meets the criteria in § 412.22(h) or § 412.22(h)(3)(i) of this part.

(c) *Patients admitted from the hospital located in the same building or on the same campus as the long-term care hospital or satellite facility.* Except for a long-term care hospital or a long-term care hospital satellite facility that meets the requirements of paragraphs (d) or (e) of this section, payments to the long-term care hospital for patients admitted to it or to its long-term care hospital satellite facility from the co-located hospital are made under either of the following:

(1) *For cost reporting periods beginning on or after October 1, 2004 and before December 29, 2007 and for cost reporting periods beginning on or after December 29, 2010.*

(i) Except as provided in paragraphs (g) and (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before December 29, 2007 and for cost reporting periods beginning on or after December 29, 2010

in which the long-term care hospital or its satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the hospital or its satellite facility from the co-located hospital, payments are made under the rules at §§ 412.500 through 412.541 in this subpart with no adjustment under this section.

(ii) Except as provided in paragraph (g) or (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before December 29, 2007 and for cost reporting periods beginning on or after December 29, 2010 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that would be determined under the rules at § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at §§ 412.500 through 412.541 with no adjustment under this section.

(iii) In determining the percentage of patients admitted to the long-term care hospital or its satellite from the co-located hospital under paragraphs (c)(1)(i) and (c)(1)(ii) of this section, patients on whose behalf an outlier payment was made to the co-located hospital are not counted towards the 25 percent threshold.

(2) *For cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010.*

(i) Except for a long-term care hospital and long-term care hospital satellite facility subject to paragraphs (g) or (h) of this section, payments are determined using the methodology specified in paragraph (c)(1) of this section.

(ii) Payments for a long-term care hospital and long-term care hospital satellite facility subject to paragraph (g) of this section are determined using the methodology specified in paragraph (c)(1) of this section except that 25 percent is substituted with 50 percent.

(d) Special treatment of rural hospitals.

(1) *For cost reporting periods beginning on or after October 1, 2004 and before December 29, 2007 and for cost reporting periods beginning on or after December 29, 2010.*

(i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in § 412.503 and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 and before December 29, 2007 and for any cost reporting period beginning on or after December 29, 2010 in which the long-term care hospital or long-term care satellite facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who were admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that were otherwise payable under § 412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's patients are made under the rules in this subpart at §§ 412.500 through 412.541 with no adjustment under this section.

(ii) In determining the percentage of patients admitted from the co-located hospital under paragraph (d)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the 50 percent threshold.

(2) For cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010.

(i) Except for long-term care hospitals and long-term care hospital satellite facilities subject to paragraphs (g) or (h) of this section, payments are determined using the methodology specified in paragraph (d)(1) of this paragraph.

(ii) Payments for long-term care hospitals and long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (d)(1) of this section except that 50 percent is substituted with 75 percent.

(e) Special treatment of urban single or MSA-dominant hospitals.

(1) *For cost reporting periods beginning on or after October 1, 2004 and before December 29, 2007 and for cost reporting periods beginning on or after December 29, 2010.*

(i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or a long-term care hospital satellite facility that is co-located with the only other hospital in the MSA or with a MSA-dominant hospital as defined in paragraph (e)(1)(iv) of this paragraph, for any cost reporting period beginning on or after October 1, 2004 and before December 29, 2007 and for any cost reporting periods beginning on or after December 29, 2010 in which the long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (e)(1)(ii) of this paragraph were admitted to the hospital from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital to exceed the applicable threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that otherwise would be determined under § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart with no adjustment under this section.

(ii) For purposes of paragraph (e)(1)(i) of this paragraph, the percentage used is the percentage of total Medicare discharges in the Metropolitan Statistical Area in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case is less than 25 percent or more than 50 percent.

(iii) In determining the percentage of patients admitted from the co-located hospital under paragraph (e)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the applicable threshold.

(iv) For purposes of this paragraph, an ''MSA-dominant hospital'' is a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located.

(2) For cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010.

(i) Except for long-term care hospitals and long-term care hospital satellite facilities subject to paragraphs (g) or (h) of this section, payments are determined using the methodology specified in paragraph (e)(1) of this section.

(ii) Payments for long-term care hospitals and long-term care hospital satellite facilities subject to paragraph

(g) of this section are determined using the methodology specified in paragraph (e)(1) of this section except that 75 percent is substituted for 50 percent.

* * * * *

(h) *Effective date of policies in this section for certain co-located LTCH hospitals and satellites of LTCHs.* The policies set forth in this section apply to Medicare patient discharges that were admitted from a hospital located in the same building or on the same campus as a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f) and a satellite facility of a long-term care hospital as described at § 412.22(h)(3)(i) for discharges occurring in cost reporting periods beginning on or after July 1, 2007.

(1) Except as specified in paragraph (h)(4) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is described under paragraph (h) of this section, the thresholds applied at paragraphs (c), (d), and (e) of this section are not less than the following percentages:

(i) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the lesser of 75 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or long-term care hospital satellite facility from its co-located hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the long-term care hospital or satellite from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(ii) For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the lesser of 50 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or the long-term care hospital satellite facility from its co-located hospital or the percentage of Medicare discharges that had been admitted from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(iii) For cost reporting periods beginning on or after July 1, 2009, 25 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or satellite from its co-located hospital during the cost reporting period.

(2) In determining the percentage of Medicare discharges admitted from the co-located hospital under this paragraph, patients on whose behalf a Medicare high cost outlier payment was made at the co-located referring hospital are not counted toward this threshold.

(3) Except as specified in paragraph (h)(4) of this section, for cost reporting periods beginning on or after July 1, 2007, payments to long term care hospitals described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(f) and satellite facilities of long-term care hospitals described at § 412.22(h)(3)(i) are subject to the provisions of § 412.536 for discharges of Medicare patients who are admitted from a hospital not located in the same building or on the same campus as the LTCH or LTCH satellite facility.

(4) For a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f), the policies set forth in this paragraph and in § 412.536 of this part do not apply for discharges occurring in cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010.

■ 5. Section 412.536 is amended by revising paragraph (a) to read as follows:

§ 412.536 Special payment provisions for long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital.

(a) *Scope.* (1) Except as specified in paragraph (a)(2) of this section, for cost reporting periods beginning on or after July 1, 2007, the policies set forth in this section apply to discharges from the following:

(i) Long-term care hospitals as described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(e).

(ii) Long-term care hospitals as described in § 412.23(e)(2)(i) and that meet the criteria in § 412.22(f).

(iii) Long-term care hospital satellite facilities as described in § 412.23(e)(2)(i) and that meet the criteria in § 412.22(h).

(iv) Long-term care hospitals as described in § 412.23(e)(5).

(2) For cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010, the policies set forth in this section are not applicable to discharges from a long-term care hospital described in § 412.23(e)(5) of this part or described in § 412.23(e)(2)(i) of this part and that meet the criteria specified in § 412.22(f) of this part.

* * * * *

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

Dated: May 8, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: May 15, 2008.

Michael O. Leavitt,

Secretary.

[FR Doc. 08–1285 Filed 5–16–08; 4:00 pm]

BILLING CODE 4120–01–P

COMMISSION OF FINE ARTS

45 CFR Part 2102

Procedures and Policies

AGENCY: The Commission of Fine Arts.

ACTION: Final rule.

SUMMARY: This document amends the procedures and policies governing the administration of the U.S. Commission of Fine Arts. It serves to modify the time limit on a recommendation for concept approval for projects submitted to the Commission under the Old Georgetown Act and the Shipstead-Luce Act in order to address more consistently the requirements and procedures of the District of Columbia government.

DATES: Effective June 16, 2008.

FOR FURTHER INFORMATION CONTACT: Thomas Luebke, Secretary, (202) 504–2200.

SUPPLEMENTARY INFORMATION: As established by Congress in 1910, the Commission of Fine Arts is a small independent advisory body made up of seven Presidentially appointed ''well qualified judges of the arts'' whose primary role is architectural review of designs for buildings, parks, monuments and memorials erected by the Federal or District of Columbia governments in Washington, DC. In addition to architectural review, the Commission considers and advises on the designs for coins, medals, and U.S. memorials on foreign soil. The Commission also advises the District of Columbia government on private building projects within the Georgetown Historic District, the Rock Creek Park perimeter, and the Monumental Core area. The Commission advises Congress, the President, Federal agencies, and the District of Columbia government on the general subjects of design, historic preservation, and on orderly planning on matters within its jurisdiction.

Specific items this document amends clarify the procedure. Therefore, as these changes clarify established procedures and are minor in nature, the Commission determines that notice and comment are unnecessary and that, in accordance with 5 U.S.C. 553(b)(B),