

an IRF, or a SNF, the interrupted stay policy at § 412.531 applies until the 5-percent threshold is reached. However, once the applicable threshold is reached, all such discharges and readmittances to the applicable site(s) for that cost reporting period are paid as one discharge. This means that even if a discharged LTCH Medicare patient was readmitted to the LTCH following a stay in an acute care hospital of greater than 9 days, if the facilities share a common location and the 5-percent threshold were exceeded, the subsequent discharge from the LTCH will not represent a separate hospitalization for payment purposes. Only one LTC-DRG payment will be made for all such discharges during a cost reporting period to the acute care hospital, regardless of the length of stay at the acute care hospital, that are followed by readmittances to the onsite LTCH.

Similarly, if the LTCH has exceeded its 5-percent threshold for all discharges to an onsite IRF, SNF, or psychiatric hospital or unit with readmittances to the LTCH, the subsequent LTCH discharge for patients from those sites for the entire cost reporting period will not be treated as a separate discharge for Medicare payment purposes. (As under the interrupted stay policy, payment to an acute care hospital under the IPPS, to an IRF under the IRF PPS, and to a SNF under the SNF PPS, will not be affected. Payments to the psychiatric facility also will not be affected.)

e. Treatment of Swing Beds Under the Interrupted Stay and Onsite Discharge and Readmittance Policies

A swing-bed hospital is defined at § 413.114(b) as a hospital or critical access hospital (CAH) participating in Medicare that has an approval from CMS to provide posthospital SNF care as defined in § 409.20 and meets the requirements specified in § 482.66 or § 485.645. Swing beds are otherwise licensed hospital beds that may, under certain circumstances, be used temporarily as SNF beds. Under § 413.114(a)(2), posthospital SNF care furnished in general routine inpatient beds in rural hospitals (other than CAHs) is paid in accordance with the provisions of the SNF PPS for services furnished for cost reporting periods beginning on or after July 1, 2002. Since it is possible for a Medicare beneficiary to be discharged from a LTCH for posthospital SNF care that is being provided by another hospital-level Medicare provider with swing beds, such a discharge would be considered the same as if it were to a individual SNF. We interpret the extension of the

SNF PPS to swing beds to require that all payment policy determinations regarding patient movement between LTCHs and SNFs, including the onsite policy described above, also apply to swing beds.

We want to emphasize that our inclusion of swing beds in payment policy determinations for all patient movement between LTCHs and SNFs (see section VI.C.4.c. of this preamble) would mean that a readmission to a LTCH from posthospital SNF care being provided in a swing bed that is located either in the LTCH itself or in another onsite Medicare provider would have the same policy consequences as would a readmission to the LTCH from an onsite SNF.

5. Other Proposed Payment Adjustments

As indicated earlier, we had broad authority under section 123 of Pub. L. 106–113, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs. Thus, in the August 30, 2002 final rule (67 FR 56014–56027), we discussed our extensive data analysis and rationale for not implementing an adjustment for geographic reclassification, rural location, treating a disproportionate share of low-income patients (DSH), or indirect medical education (IME) costs. In that same final rule, we stated that we would collect data and reevaluate the appropriateness of these adjustments in the future once more LTCH data become available after the LTCH PPS is implemented. Because the LTCH PPS was only recently implemented, sufficient new data have not yet been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. Therefore, we are not proposing an adjustment for geographic reclassification, rural location, DSH, or IME at this time. However, we will continue to collect and interpret new data as they become available in the future to determine if these data support proposing any additional payment adjustments.

6. Proposed Budget Neutrality Offset to Account for the Transition Methodology

Under § 412.533, we implemented a 5-year transition period from cost-based TEFRA reimbursement to prospective payment, during which a LTCH will be paid an increasing percentage of the LTCH PPS rate and a decreasing percentage of its payments under the TEFRA payment principles for each discharge. Furthermore, we allow a LTCH to elect to be paid based on 100

percent of the standard Federal rate in lieu of the blend methodology.

As we discussed in further detail in the August 30, 2002 final rule (67 FR 56032–56037), the standard Federal rate was determined as if all LTCHs will be paid based on 100 percent of the standard Federal rate. As stated earlier, we provide for a 5-year transition period methodology that allows LTCHs to receive payments based partially on reasonable cost principles. In order to maintain budget neutrality as required by section 123(a)(1) of the Pub. L. 106–113 and § 412.523(d)(2), during the 5-year transition period, we reduce all LTCH Medicare payments (whether a LTCH elects payment based on 100 percent of the Federal rate or whether a LTCH is being paid under the transition blend methodology) by a factor that is equal to 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would have been made if the LTCH PPS had not been implemented, to the projected total Medicare program PPS payments (that is, payments made under the transition methodology and the option to elect payment based on 100 percent of the Federal rate).

For FY 2003, based on a comparison of the estimated FY 2003 payments to each LTCH based on 100 percent of the standard Federal rate and the transition blend methodology, we projected that approximately 49 percent of LTCHs would elect to be paid based on 100 percent of the standard Federal rate rather than receive payment based on the transition blend methodology. This projection was based on our estimate that those 49 percent of LTCHs would receive higher payments based on 100 percent of the standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we projected that the remaining 51 percent of LTCHs would choose to be paid based on the transition blend methodology (80 percent of TEFRA and 20 percent of the PPS) in FY 2003, because those payments would be higher than if they were paid based on 100 percent of the standard Federal rate.

In the August 30, 2002 final rule (67 FR 56034), we projected that the full effect of the 5-year transition period and the election option would result in a cost to the Medicare program of \$240 million as follows: For FY 2003, \$50 million; for FY 2004, \$80 million; for FY 2005, \$60 million; for FY 2006, \$40 million; for FY 2007, \$10 million. Thus, in order to maintain budget neutrality, we applied a 6.6 percent reduction (0.934) to all LTCHs' payments in FY 2003 to account for the estimated cost