

that we would 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.

*Comment:* Two commenters objected to our proposal not to include an adjustment to account for a hospital's treatment of a disproportionate share of low-income patients (a DSH adjustment) or an adjustment to account for indirect teaching costs (an IME adjustment). One commenter stated that given that LTCHs are a heterogeneous group of facilities with widely varying costs and patient populations, it is particularly important to provide adjustments to compensate for the differences where possible. The other commenter stated that the LTCH regression analysis was among a diverse set of facilities, thus weakening CMS' conclusions not to include adjustments for DSH and IME. Accordingly, both commenters urged for the inclusion of a DSH adjustment and an IME adjustment in the LTCH PPS.

*Response:* As we discussed in the August 30, 2002, final rule (67 FR 56020–56022), we examined the appropriateness of an adjustment for LTCHs serving a disproportionate share of low-income patients. In that same final rule, we explained that in examining the most recent LTCH data available to us, we determined that a DSH adjustment consistent with the DSH adjustment under the IPPS for acute care hospitals (set forth at section 1886(d)(5)(F) of the Act) would reduce the ability of the LTCH PPS to predict cost per case while lowering the base payment rate. We also evaluated alternative methods to provide some type of DSH adjustment. Specifically, using regression analysis that took into account both the Medicaid patients receiving SSI and the percentage of Medicaid patients not entitled to Medicare, we found no significant empirical relationship between these variables and LTCHs' costs. Therefore, we did not establish a DSH adjustment under the LTCH PPS.

Also, in the August 30, 2002, final rule (67 FR 56022), we explained that based on a double log regression, we found that the indirect teaching cost variable was negative and not significant. In addition, we looked at different specifications for the teaching variable, including resident-to-bed ratio and resident-to-average daily census, to measure teaching intensity. In all of our payment regressions it was determined that the teaching variable was not significant; that is, no empirical evidence exists to show that LTCHs' cost per case would vary with teaching costs.

In the March 7, 2003, proposed rule (68 FR 11254), we explained that 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, since we still do not have empirical evidence to support a DSH adjustment or an IME adjustment, we continue to believe that it would be inappropriate to establish such adjustments at this time. Accordingly, in this final rule, we are not adopting the commenters' suggestion to include a DSH adjustment and an IME adjustment in the LTCH PPS. As we stated in the March 7, 2003, proposed rule (68 FR 11254), 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. Budget Neutrality Offset To Account for the Transition Methodology

In the August 30, 2002, final rule (67 FR 56038) under § 412.533, we implemented a 5-year transition period from reasonable cost-based payment 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 reasonable cost-based 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-based principles. In order to maintain budget neutrality as required by section 123(a)(1) of the Public Law 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). Specifically, we reduce all LTCH Medicare payments during the 5-year transition 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 reasonable cost-based payments and 20 percent of payments based on the Federal rate) 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 of \$50 million for FY 2003. Furthermore, in order to maintain budget neutrality, we indicated that, in the future, we would propose a budget neutrality offset for each of the remaining years of the transition period to account for the estimated payments for the respective fiscal year. Based on the data available at that time, in the August 30, 2002, final rule (67 FR 56037) we estimated the following budget neutrality offsets to LTCH payments during the remainder of the transition period: 5.0 percent (0.950) in FY 2004; 3.4 percent (0.966) in FY 2005; and 1.7 percent (0.983) in FY 2006. We also stated that no budget neutrality offset is necessary in the 5th year of the transition period (FY 2007) because under the transition methodology at § 412.533, all LTCHs will be paid based on 100 percent of the standard Federal rate and zero percent of the reasonable cost-based principles.

As stated in the March 7, 2003, proposed rule (68 FR 11254–11256), for the proposed 2004 LTCH PPS rate year,