

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 981</b>	<b>Date: JUNE 15, 2006</b>
	<b>Change Request 5202</b>

**Subject: Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2007**

**I. SUMMARY OF CHANGES:** We are required to update the payments made under this prospective payment system annually. The Rate Year update occurs every July.

Comments:

**New / Revised Material**

**Effective Date: July 1, 2006**

**Implementation Date: July 3, 2006**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

<b>R/N/D</b>	<b>Chapter / Section / Subsection / Title</b>
<b>R</b>	3/20.2.3.1/Provider-Specific File
<b>R</b>	3/150.9.1.1/Short-Stay Outliers
<b>R</b>	3/150.9.1.2/Interrupted Stays
<b>R</b>	3/150.9.1.4/Payment Policy for Co-Located Providers
<b>R</b>	3/150.23.1/Inputs/Outputs to Pricer

**III. FUNDING:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

**IV. ATTACHMENTS:**

**Recurring Update Notification Manual**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 981	Date: June 15, 2006	Change Request 5202/R30601
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**SUBJECT: Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2007**

## I. GENERAL INFORMATION

**A. Background:** On October 1, 2002, CMS implemented, through an August 30, 2002 **Federal Register** document, a prospective payment system for LTCHs under the Medicare program in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Payments under this system are made on a per discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data. We are required to update the payments made under this prospective payment system annually. There are two significant updates for LTCH PPS. The Rate Year update occurs in July of each year and the DRGs are updated in October of each year.

## B. Policy:

### 1. PRICER Updates: For LTCH PPS rate year (RY) 2007, (July 1, 2006 – June 30, 2007)

- The standard Federal rate is \$38,086.04.
- The fixed loss amount is \$14,887.00.
- The budget neutrality adjustment is 0 percent. (The PRICER payment amount will include the adjustment factor as 1.00.)
- The wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2006 is 5/5<sup>th</sup> (100 percent). The wage index table within the PRICER will include three columns:
  - a 3/5<sup>th</sup> column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2005,
  - a 4/5<sup>th</sup> column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2006, and
  - a 5/5<sup>th</sup> column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2007.
- The labor-related share is 75.665 percent.
- The non-labor related share is 24.335 percent.
- The short-stay outlier percentage for a “subsection (II)” LTCH is 136 percent for this 4<sup>th</sup> transition year (i.e., FY 2006).

### 2. Short Stay Outlier Calculation Changes

- Currently, under §412.529, short-stay outlier (SSO) cases (i.e., cases with a length of stay less than or equal to 5/6 of the geometric average length of stay (ALOS) of the LTC diagnosis related groups

(DRG)), are paid the least of 120 percent of the estimated cost of the case; 120 percent of the LTC-DRG per diem amount; or the full LTC-DRG payment.

- In the 2007 LTCH PPS rate year final rule, CMS revised the payment formula for SSO cases to provide less of a financial incentive for an LTCH to admit patients that could be more appropriately continue to be treated in acute care hospitals rather than discharged to a LTCH for a short stay. Therefore, under the revised policy, for LTCH discharges that are SSOs occurring on or after RY 2007, the option of the current SSO payment formula that is based on estimated costs will be reduced from 120 percent to 100 percent to ensure that payments do not substantially exceed costs. In addition, a fourth option is being added to the SSO payment formula, which is a blended payment based on a percentage of an inpatient prospective payment system (IPPS) comparable amount computed as a per diem and capped at the full IPPS comparable amount and a percentage of the 120 percent of the LTC-DRG per diem amount. Under this fourth component to the SSO payment formula, as the length of the stay increases, the stay begins to resemble less of a short-term acute care stay and more of a typical LTCH stay, and therefore, the LTCH PPS payment is based on a decreasing percentage of the IPPS comparable per diem amount and an increasing percentage of the 120 percent of the LTC-DRG per diem amount.
- Effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case will equal the least of:
  - 100 percent of estimated cost of the case,
  - 120 percent of the LTC-DRG per diem amount,
  - the full LTC-DRG payment, or
  - a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and 120 percent of the LTC-DRG per diem amount.

Under the blend alternative, the percentage of the 120 percent of the LTC-DRG per diem amount will be based on the ratio of the (covered) length of stay of the case to the lesser of the SSO threshold for the LTC-DRG (i.e., 5/6ths of the geometric ALOS of the LTC-DRG) or 25 days. As the length of stay reaches the lower of the five-sixths SSO threshold or 25 days, the adjusted SSO payment will no longer be limited by this fourth option. This is because for SSO cases with a LOS of 25 days or more and for stays that equal the 5/6<sup>th</sup> SSO threshold or more, the amount determined under the blend alternative is equal to 100 percent of the 120 percent of the LTC- DRG specific per diem amount and 0 percent of the IPPS comparable per diem amount. In addition, the LOS in the numerator cannot exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent). The remaining percent of the blend alternative (that is, 100 percent minus the percentage applied to the 120 percent of the LTC-DRG per diem amount) will be applied to the IPPS comparable per diem amount (capped at the full IPPS comparable amount).

The following examples illustrate how the blend alternative is calculated when the LTCH patient is grouped to hypothetical DRG XYZ. For purposes of this example, for DRG XYZ, the *full LTC DRG payment* is \$38,597.41, the *LTCH PPS geometric ALOS* is 33.6 days, the *LTCH PPS SSO threshold* (i.e., 5/6ths of the geometric ALOS) is 28.0 days, the *full IPPS comparable amount* is \$8,019.82, and the *IPPS geometric ALOS* is 4.5 days.

**SSO Example #1 – LOS equals 11 Days:**

<b>Step Number</b>	<b>Description of Step</b>	<b>Description of Calculation</b>	<b>Example of Calculation</b>	<b>Result</b>
<b>1a</b>	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$\frac{\$38,597.41}{33.6 \text{ days}} \times 11 \text{ days} \times 1.2$	\$15,163.27
<b>1b*</b>	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6 <sup>th</sup> ALOS of LTC-DRG XYZ or 25 days	11 days ÷ 25 days	0.44
<b>1c</b>	Determine the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the LTC-DRG per diem amount in step (1-a)	0.44 x \$15,163.28	\$6,671.84
<b>2a</b>	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$\frac{\$8,019.82}{4.5 \text{ days}} \times 11 \text{ days}$	\$19,604.00
<b>2b</b>	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount (\$8,019.82) is lower than the IPPS comparable per diem amount (\$19,604.00)	\$8,019.82
<b>2c</b>	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6 <sup>th</sup> ALOS of LTC-DRG XYZ or 25 days)	1 – 0.44	0.56
<b>2d</b>	Determine the IPPS comparable per diem portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable amount determined in step (2-b)	0.56 x \$8,019.82	\$4,491.10
<b>3</b>	Compute the blend alternative	Add the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	\$6,671.84 + \$4,491.10	\$11,162.94

\* In this example, 25 days was used in the denominator since the 5/6<sup>th</sup> ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6<sup>th</sup> ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

**SSO Example #2 – LOS equals 27 Days:**

<b>Step Number</b>	<b>Description of Step</b>	<b>Description of Calculation</b>	<b>Example of Calculation</b>	<b>Result</b>
<b>1a</b>	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$\frac{\$38,597.41}{33.6 \text{ days}} \times 27 \text{ days}$ $\times 1.2$	\$37,218.93
<b>1b*</b>	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6 <sup>th</sup> ALOS of LTC-DRG XYZ or 25 days; however, since the LOS in the numerator exceeds the number of days in the denominator, the percentage equals 100 percent	$27 \text{ days} \div 25 \text{ days}$ is $> 1$ ; therefore percent is 1.00	1.00
<b>1c</b>	Determine the 120 percent of the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the 120 percent of the LTC-DRG per diem amount in step (1-a)	$1.0 \times \$37,218.93$	\$37,218.93
<b>2a</b>	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$\frac{\$8,019.82}{4.5 \text{ days}} \times 27 \text{ days}$	\$48,118.92
<b>2b</b>	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount (\$8,019.82) is lower than the IPPS comparable per diem amount (\$48,118.92)	\$8,019.82
<b>2c</b>	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6 <sup>th</sup> ALOS of LTC-DRG XYZ or 25 days)	$1 - 1.00$	0.00
<b>2d</b>	Determine the IPPS comparable per diem amount portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable per diem amount determined in step (2-b)	$0.00 \times \$8,019.82$	\$0.00

<b>3</b>	Compute the blend alternative	Add the 120 percent of the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$\$37,218.93 + \$0.00$	$\$37,218.93^{**}$
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\* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

\*\* Note that, since in this example the LOS of the SSO case exceeds 25 days, the blend percentage applicable to the 120 percent of the LTC-DRG specific per diem amount is 100 percent and the percentage applicable to the IPPS comparable per diem amount is 0 percent, therefore the amount computed under the blend option is equal to 120 percent of the LTC-DRG specific per diem amount.

Under the blend alternative of the SSO payment formula, an amount comparable to what would otherwise be paid under the IPPS for the costs of inpatient operating services (i.e., full IPPS comparable amount) is based on the standardized amount determined under §412.64(c), adjusted by the applicable DRG weighting factors determined under §412.60 as specified at §412.64(g). This amount is further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at §412.525(c) and using the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (Currently, the same COLA factors are used under both the IPPS and the LTCH PPS.) Additionally, an IPPS comparable amount for the case will include a disproportionate share (DSH) adjustment (see §412.106), if applicable, and include an indirect medical education (IME) adjustment (see §412.105), if applicable. For the comparable IPPS DSH adjustment, provider specific file elements 24 (Bed Size), 27 (Supplemental Security Income (SSI) Ratio), and 28 (Medicaid Ratio) will be required, as discussed below. In determining a LTCH's SSI ratio and Medicaid ratio used in the calculation of the comparable IPPS DSH adjustment, refer to the Internet Only Manual (IOM) Pub. 100-04, Chapter 3, Section 20.3.1.1 and 20.3.1.2. For the comparable IPPS IME adjustment, provider specific file elements 23 (Intern/Beds Ratio) and 49 (Capital Indirect Medical Education Ratio) will be required, as discussed below. Furthermore, the IPPS comparable IME adjustment for a LTCH is determined by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCH's direct GME cap as set forth at §413.79(c)(2) (which will already be established for a LTCH which had residency programs). In determining the IPPS comparable IME adjustment for a LTCH, if applicable, the use of a proxy for the IME cap is necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. The full IPPS comparable amount used under the blend alternative in the SSO payment adjustment, also includes payment for inpatient capital-related costs, based on the capital Federal rate at §412.308(c), which is adjusted by the applicable IPPS DRG weighting factors. This amount is further adjusted by the applicable geographic adjustment factors set forth at §412.316, including wage index (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals as published in the annual IPPS final rule), and large urban location, if applicable. An IPPS comparable amount does not include additional payments for extraordinarily high cost cases under the IPPS outlier policy (§412.80(a)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS high cost outlier payment at §412.525(a) (1) (i.e., if the estimated costs of the case exceeds the adjusted

LTCH PPS SSO payment plus the fixed-loss amount) will receive an additional payment under the LTCH PPS HCO high cost outlier at §412.525(a) (67 FR 56026; August 30, 2002). Under the revised SSO payment formula, we will continue to use the fixed-loss amount calculated under §412.525(a), and not a fixed-loss amount based on §412.80(a), to determine whether a SSO case receives an additional payment as a high cost outlier case.

### **3. Provider Specific File (PSF) Updates**

We are modifying the inputs to the LTCH Provider Specific File to include the following Data Elements. These elements will be used in the new short stay outlier calculation to determine the comparable IPPS payment.

- 23 Intern/Beds Ratio
- 24 Bed Size
- 27 Supplemental Security Income Ratio-Refer to the following website:  
[http://www.cms.hhs.gov/LongTermCareHospitalPPS/08\\_download.asp](http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp)
- 28 Medicaid Ratio
- 49 Capital Indirect Medical Education Ratio

The existing CBSA 46940 (Vero Beach, FL) has been renamed Sebastian-Vero Beach, FL (CBSA 42680). The CBSA code for any LTCHs currently in CBSA 46940 will need to be changed to CBSA 42680 effective July 1, 2006. (Note, the wage index table published in the Federal Register & the one used by the LTCH PRICER reflects this change.)

### **4. 3-Day or Less Interruption of Stay**

Presently, all treatment and/or care (both inpatient and outpatient) delivered to LTCH patients by acute care hospitals, IRFs, and SNFs during a 3 day or less interruption is the responsibility of the LTCH “under arrangements” unless the patient’s treatment at an acute care hospital during such an interruption was grouped to a surgical DRG. In that case, for RY 2005 and RY 2006, CMS provided an exception, and the acute care hospital was allowed to submit a separate bill to Medicare for the services delivered. (The patient’s readmittance to the LTCH following the surgical procedure, however, continued to be governed by the interrupted stay policy.)

For RY 2007, CMS is discontinuing the surgical-DRG exception to the 3-day or less interruption of stay policy at former 412.531(b) (i) (C) and (b) (ii) (A) (1) and is requiring that LTCHs cover such treatment “under arrangements” as is presently the case for all other medical care or services provided to inpatients during a 3 day or less interruption of stay. Therefore, for LTCH discharges occurring on or after July 1, 2006, governed by the 3 day or less interruption of stay policy, an acute care hospitals will no longer submit a separate bill to Medicare for treatment delivered to a beneficiary who was admitted to the acute care hospital from an LTCH and who will return to that LTCH within 3 days, but must turn to the LTCH for payment for services grouped to a surgical DRG.



Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.								

**IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS**

**A. Other Instructions: N/A**

X-Ref Requirement #	Instructions
5202.2	CMS requests that all FIs look at CR 4279 and make sure all fields are current. CMS programmers have noticed that not all PSFs have Data Element 9, Provider Type entered.

**B. Design Considerations: N/A**

X-Ref Requirement #	Recommendation for Medicare System Requirements
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**C. Interfaces: LTCH PRICER version 070**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: Contractors shall test all three columns of the wage index and the new short stay outlier logic in addition to normal testing.**

## V. SCHEDULE, CONTACTS, AND FUNDING

<p><b>Effective Date*:</b> discharges on or after July 1, 2006</p> <p><b>Implementation Date:</b> July 3, 2006</p> <p><b>Pre-Implementation Contact(s):</b> <u>Policy:</u> Michele Hudson at (410) 786-5490 or Judy Richter at (410) 786-2590. <u>Claims Processing &amp; PRICER:</u> Sarah Shirey-Losso at (410) 786-0187 or Valeri Ritter at (410) 786-8652</p> <p><b>Post-Implementation Contact(s):</b> Appropriate CMS Regional Office</p>	<p><b>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</b></p>
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**\*Unless otherwise specified, the effective date is the date of service.**

### **20.2.3.1 - Provider-Specific File**

*(Rev. 981, Issued: 06-15-06; Effective: 07-01-06; Implementation: 07-03-06)*

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. The FI maintains the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the FI prepares an additional record showing the effective date. For example, when a hospital's FY beginning date changes as a result of a change in ownership or other "good cause," the FI makes an additional record showing the effective date of the change.

The format and data required by the PRICER program and by the provider-specific file is found in [Addendum A](#).

The FIs submit a file of provider-specific payment data to CMS CO every three months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), SNFs, and hospices, including those in Maryland. Regional home health FIs (RHHIs) submit a file of provider specific data for all home health agencies. FIs serving as the audit FI for hospital based HHAs do not submit a file of provider specific data for HHAs.

The FIs create a new record any time a change occurs for a provider. Data must be reported for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within seven business days after the end of the period being reported.

**NOTE:** FIs submit the latest available provider-specific data for the entire reporting period to CO by the seven-business day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period, the FI may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, the FI may exclude the October 1 CO-required changes from the file submitted by October 9. The FI includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

#### **A. PPS Hospitals**

The FIs submit all records (past and current) for all PPS providers every three months. Duplicate the provider file used in the "PRICER" module of the claims processing system.

## **B. Non-PPS Hospitals and Exempt Units**

The FIs create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every three months. Code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file.

## **C. Hospice**

The FIs create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all hospices. Data elements 33 and 38 are optional and may be populated if needed.

## **D. Skilled Nursing Facility (SNF)**

The FIs create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998. The FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all SNFs. Data elements 33 and 38 are required if there is a special wage index. Effective October 1, 2005, through September 30, 2006, data elements 33 and 38 are required since there is a special wage index.

## **E. Home Health Agency (HHA)**

The FIs create a provider specific history file using the following data elements for each HHA. Regional home health FIs (RHHIs) submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

## **F. Inpatient Rehabilitation Facilities (IRFs)**

The FIs create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements *1, 2*, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 18, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all IRFs. Data elements *17, 33, 38, and 49* are required if applicable to the IRF.

## **G. Long Term Care Hospital (LTCH)**

The FIs create a provider specific history file using the following data elements for each LTCH beginning with their first cost reporting period that starts on or after October 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements *1, 2*, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, *18*, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

Effective July 1, 2005, data element 35 is required. Data elements 33 and 38 are optional and may be populated if needed. Data elements 12, 13, and 14 are no longer applicable.

*Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required.*

## **H. Inpatient Psychiatric Facilities (IPF)**

The FIs create a provider specific history file using the following data elements for each IPF beginning with their first cost reporting period that starts on or after January 1, 2005. The FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, *2*, 3, 4, 5, 6, 7, 8, *9*, 10, 13, *17*, 18, 19, 21, 22, 23, 25, 33, 35, 38, and 48 are required. All other data elements are optional for this provider type. Although data element 25 refers to the operating cost to charge ratio, ensure that both operating and capital cost-to-charge ratio are entered in data element 25 for IPFs. Ensure that data element 21 (Facility Specific Rate) will be determined using the same methodology to determine the interim payment per discharge under the TEFRA system.

*Effective July 1, 2006, data element 13 is no longer required. Data elements 33 and 38 are optional and may be populated if needed.*

**NOTE:** All data elements, whether required or optional, must have a default value of “0” (zero) if numerical, or a blank value if alphanumeric.

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. FIs must set up an NDM transfer from the FI's system for which it is responsible. It is critical that the provider specific data is copied to the CMS Data Center using the following input data set names ("99999" should be changed to the FI's 5-digit number):

Data set Name ---COPY TO: [--MU00.@FPA2175.intermediary99999](#)

DCB=(HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)

Data set Name ---RUN JOB: [--MU00.@FPA2175.CLIST\(intermediary99999\)](#)

See [Addendum A](#) for the Provider Specific File record layout and description.

### 150.9.1.1 - Short-Stay Outliers

*(Rev. 981, Issued: 06-15-06; Effective: 07-01-06; Implementation: 07-03-06)*

Generally, a short-stay outlier is a case that has a length of stay between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped. A short-stay outlier is paid the least of:

- 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio and covered charges from the bill);
- 120 percent of the LTC-DRG specific per diem payment (determined using the LTC-DRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case); or
- The full LTC-DRG payment.

#### To compute 120% of cost:

- Charges x CCR = Cost (\$13,870.33) x (0.8114) = \$11,254.39
- 120% of cost = \$11,254.39 x 1.2 = \$13,505.27

#### To compute 120% of the specific LTC-DRG per diem:

- Full LTC-DRG payment / ALOS LTC-DRG x LOS of the case x 1.2

Full LTC-DRG payment:

\$34,956.15 (FY 2003 standard Federal rate)

x 0.72885 (labor %)

\$25,477.79 (labor share)

x 1.0301 (1/5<sup>th</sup> wage index value for FY 2003)

\$26,244.67 (wage adjusted labor share)

+ 9,478.36 (non-labor share=\$34,956 x 0.27115)

\$35,723.03 (adjusted standard Federal rate)

x 1.4103 (LTC-DRG 113 relative weight)

\$50,380.19 (full LTC-DRG payment)

Per Diem = \$50,380.19 / 36.9 (ALOS LTC-DRG 113) = \$1365.32 per day  
If LOS of case is 10 days, then 120% of per diem = \$1365.32 per day x 10 days x 1.2 = \$16,383.80.

In this example, the case is paid 120% of cost (\$13,505.27) since it is less than 120% of the specific LTC-DRG per diem (\$16,383.80) and the full LTC-DRG payment (\$50,380.19).

For discharges occurring on or after August 8, 2003, short-stay outlier payments are to be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

***For RY 2007, the SSO policy was revised as follows:***

- *Effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case will equal the least of:*
  - *100 percent of estimated cost of the case,*
  - *120 percent of the LTC-DRG per diem amount,*
  - *the full LTC-DRG payment, or*
  - *a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and 120 percent of the LTC-DRG per diem amount.*

*Under the blend alternative, the percentage of the 120 percent of the LTC-DRG per diem amount will be based on the ratio of the (covered) length of stay of the case to the lesser of the SSO threshold for the LTC-DRG (i.e., 5/6ths of the geometric ALOS of the LTC-DRG) or 25 days. As the length of stay reaches the lower of the five-sixths SSO threshold or 25 days, the adjusted SSO payment will no longer be limited by this fourth option. This is because for SSO cases with a LOS of 25 days or more, the amount determined under the blend alternative is equal to 100 percent of the 120 percent of the LTC- DRG specific per diem amount and 0 percent of the IPPS comparable per diem amount. In addition, the LOS in the numerator cannot exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent). The remaining percent of the blend alternative (that is, 100 percent minus the percentage applied to the 120 percent of the LTC-DRG per diem amount) will be applied to the IPPS comparable per diem amount (capped at the full IPPS comparable amount).*

*The following examples illustrate how the blend alternative is calculated when the LTCH patient is grouped to hypothetical DRG XYZ. For purposes of this example, for DRG XYZ, the full LTC DRG payment is \$38,597.41, the LTCH PPS geometric ALOS is 33.6*

days, the LTCH PPS SSO threshold (i.e., 5/6ths of the geometric ALOS) is 28.0 days, the full IPPS comparable amount is \$8,019.82, and the IPPS geometric ALOS is 4.5 days.

**SSO Example #1 – LOS equals 11 Days:**

<b>Step Number</b>	<b>Description of Step</b>	<b>Description of Calculation</b>	<b>Example of Calculation</b>	<b>Result</b>
<b>1a</b>	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$\frac{\$38,597.41}{33.6 \text{ days}} \times 11 \text{ days} \times 1.2$	\$15,163.27
<b>1b*</b>	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6 <sup>th</sup> ALOS of LTC-DRG XYZ or 25 days	$11 \text{ days} \div 25 \text{ days}$	0.44
<b>1c</b>	Determine the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the LTC-DRG per diem amount in step (1-a)	$0.44 \times \$15,163.28$	\$6,671.84
<b>2a</b>	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$\frac{\$8,019.82}{4.5 \text{ days}} \times 11 \text{ days}$	\$19,604.00
<b>2b</b>	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount (\$8,019.82) is lower than the IPPS comparable per diem amount (\$19,604.00)	\$8,019.82
<b>2c</b>	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6 <sup>th</sup> ALOS of LTC-DRG XYZ or 25 days)	$1 - 0.44$	0.56
<b>2d</b>	Determine the IPPS comparable per diem portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable amount determined in step (2-b)	$0.56 \times \$8,019.82$	\$4,491.10

<b>3</b>	<i>Compute the blend alternative</i>	<i>Add the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)</i>	$\$6,671.84 + \$4,491.10$	$\$11,162.94$
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*\* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).*

**SSO Example #2 – LOS equals 27 Days:**

<b>Step Number</b>	<b>Description of Step</b>	<b>Description of Calculation</b>	<b>Example of Calculation</b>	<b>Result</b>
<b>1a</b>	<i>Determine 120 percent of the LTC-DRG per diem amount</i>	<i>Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2</i>	$\frac{\$38,597.41}{33.6 \text{ days}} \times 1.2$	$\$37,218.93$
<b>1b*</b>	<i>Calculate the percentage of the 120 percent of the LTC-DRG per diem amount</i>	<i>Divide the covered LOS by the lesser of the 5/6<sup>th</sup> ALOS of LTC-DRG XYZ or 25 days; however, since the LOS in the numerator exceeds the number of days in the denominator, the percentage equals 100 percent</i>	$27 \text{ days} \div 25 \text{ days} > 1$ ; therefore percent is 1.00	$1.00$
<b>1c</b>	<i>Determine the 120 percent of the LTC-DRG per diem portion of the blend alternative</i>	<i>Multiply the percentage determined in step (1-b) by the 120 percent of the LTC-DRG per diem amount in step (1-a)</i>	$1.0 \times \$37,218.93$	$\$37,218.93$
<b>2a</b>	<i>Calculate the IPPS comparable per diem amount</i>	<i>Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS</i>	$\frac{\$8,019.82}{4.5 \text{ days}} \times 11 \text{ days}$	$\$48,118.92$
<b>2b</b>	<i>Determine the IPPS comparable per diem amount to be used in the blend alternative</i>	<i>Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount</i>	<i>The full IPPS comparable amount (\$8,019.82) is lower than the IPPS comparable per diem amount (\$48,118.92)</i>	$\$8,019.82$

<b>2c</b>	<i>Calculate the percentage of the IPPS comparable per diem amount</i>	<i>Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6<sup>th</sup> ALOS of LTC-DRG XYZ or 25 days)</i>	$1 - 1.00$	0.00
<b>2d</b>	<i>Determine the IPPS comparable per diem amount portion of the blend alternative</i>	<i>Multiply the percentage determined in step (2-c) by the IPPS comparable per diem amount determined in step (2-b)</i>	$0.00 \times \$8,019.82$	\$0.00
<b>3</b>	<i>Compute the blend alternative</i>	<i>Add the 120 percent of the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)</i>	$\$37,218.93 + \$0.00$	$\$37,218.93^{**}$

*\* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).*

*\*\* Note that, since in this example the LOS of the SSO case exceeds 25 days, the blend percentage applicable to the 120 percent of the LTC-DRG specific per diem amount is 100 percent and the percentage applicable to the IPPS comparable per diem amount is 0 percent, therefore the amount computed under the blend option is equal to 120 percent of the LTC-DRG specific per diem amount.*

*Under the blend alternative of the SSO payment formula, an amount comparable to what would otherwise be paid under the IPPS for the costs of inpatient operating services (i.e., full IPPS comparable amount) is based on the standardized amount determined under §412.64(c), adjusted by the applicable DRG weighting factors determined under §412.60 as specified at §412.64(g). This amount is further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at §412.525(c) and using the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. (In the RY 2006 LTCH PPS final rule (70 FR 24200), we discuss the inapplicability of geographic reclassification procedures for LTCHs.) For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (Currently, the same COLA factors are used under both the IPPS and the LTCH PPS.) Additionally, an amount comparable to what would be paid under the IPPS for the case will include a disproportionate share (DSH) adjustment (see §412.106), if applicable, and include an indirect medical education (IME) adjustment (see §412.105), if applicable. For the comparable IPPS DSH adjustment, provider specific file elements 24 (Bed Size), 27 (Supplemental Security Income Ratio (SSI)), and 28 (Medicaid Ratio) will be required, as discussed below. In determining a LTCH's SSI ratio and Medicaid ratio used in the calculation of the comparable IPPS DSH adjustment, refer to sections 20.3.1.1 and 20.3.1.2 of this manual.*

*For the comparable IPPS IME adjustment, provider specific file elements 23 (Intern/Beds Ratio) and 49 (Capital Indirect Medical Education Ratio) will be required, as discussed below. Furthermore, the IPPS comparable IME adjustment for a LTCH is determined by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCH's direct GME cap as set forth at §413.79(c)(2) (which will already be established for a LTCH which had residency programs). In determining the IPPS comparable IME adjustment for a LTCH, if applicable, the use of a proxy for the IME cap is necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. The full IPPS comparable amount used under the blend alternative in the SSO payment adjustment, also includes payment for inpatient capital-related costs, based on the capital Federal rate at §412.308(c), which is adjusted by the applicable IPPS DRG weighting factors. This amount is further adjusted by the applicable geographic adjustment factors set forth at §412.316, including wage index (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals as published in the annual IPPS final rule), and large urban location, if applicable. A LTCH PPS payment amount comparable to what would be paid under the IPPS does not include additional payments for extraordinarily high cost cases under the IPPS outlier policy (§412.80(a)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS high cost outlier payment at §412.525(a)(1) (i.e., if the estimated costs of the case exceeds the adjusted LTCH PPS SSO payment plus the fixed-loss amount) will receive an additional payment under the LTCH PPS HCO high cost outlier at §412.525(a) (67 FR 56026; August 30, 2002). Under the revised SSO payment formula, we will continue to use the fixed-loss amount calculated under §412.525(a), and not a fixed-loss amount based on §412.80(a), to determine whether a SSO case receives an additional payment as a high cost outlier case.*

### **Short Stay Outlier Policy for LTCHs qualifying under §1886(d)(1)(B)(II)**

A “subsection (II)” hospital:

- Was excluded as a LTCH in 1986
- Has an average inpatient LOS of greater than 20 days, and
- Demonstrates that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending FFY 1997 have a principal finding of neoplastic disease.

For a “subsection (II)” hospital there is a special short-stay outlier policy effective for the remainder of the transition period (i.e., **discharges** occurring on or after July 1, 2003 through December 31, 2006), where the lesser of 120 percent of cost or 120 percent of the per diem LTC-DRG in the existing short-stay outlier policy is replaced with the follow percentages:

- Effective for **discharges** occurring on or after **July 1, 2003 through the first year of transition 195%**;
- Effective for **discharges** during the second year of the transition, **193%**;

- Effective for **discharges** during the third year of the transition, **165%**;
- Effective for **discharges** during the fourth year of the transition, **136%**; and
- Effective for **discharges** for the last year and thereafter, the percentage will return to **120%**.

### 150.9.1.2 - Interrupted Stays

*(Rev. 981, Issued: 06-15-06; Effective: 07-01-06; Implementation: 07-03-06)*

Beginning on July 1, 2004, there are two interruption of stay policies in effect under the LTCH PPS.

A 3-day or less interruption of stay is a stay at a LTCH during which beneficiary is discharged from the LTCH to an acute care hospital, IRF, SNF, or home and readmitted to the same LTCH within 3-days of the discharge. The 3-day or less period begins with the date of discharge from the LTCH and ends not later than midnight of the third day.

Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the “interruption” would be the responsibility of the LTCH “under arrangements” with one limited exception: for RY 2005 (July 1, 2004 through June 30, 2005) if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care. *Effective for dates of service on or after July 1, 2006, this limited exception for surgical DRGs is no longer applicable. No further separate payment to an acute care hospital will be made.* Any tests or procedures, that were administered to the patient during that period of time of interruption will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

If no additional Medicare services are delivered during the 3-day or less interruption (e.g., the patient is home and doesn’t receive any outpatient or inpatient services at an acute care hospital or IRF or care at a SNF) prior to readmission to the LTCH, the number of days away from the LTCH will not be included in the total length of stay for that beneficiary stay. If care is delivered on any day during the interruption, however, that the LTCH pays for “under arrangements,” all the days of the interruption are included in the total length of stay for that beneficiary stay. Therefore, if a patient receives services on only one of the days of the interruption but is away from the LTCH for 3 days, all 3 days will be deemed a part of the total episode of care and counted towards the length of stay for that patient stay. If an interruption of stay exceeds 3-days, the original interrupted stay policy, below, governs payment.

- The original interrupted stay policy is now defined as “a greater than 3-day interruption of stay” and is a stay in which a LTCH patient that is admitted upon discharge to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or swing bed and returns to the same

LTCH within a specified period of time. The day count begins on the day of discharge from the LTCH, which is also the admission day to the other provider, and ends on the day of readmission to the LTCH.

- For an acute care hospital: between 4 and 9 consecutive days;
- For an IRF: between 4 and 27 consecutive days;
- For a SNF: between 4 and 45 consecutive days; and
- For a Swing Bed: between 4 and 45 consecutive days or less.

Note that although the greater than 3-day interruption of stay policy only governs when a patient is away from the LTCH for between 4 days and the applicable provider threshold, the day count for determining whether the threshold is met begins when the patient is discharged. So if a patient is discharged on 9/2/04, the 3-day or less interrupted stay policy will govern payment if the patient is readmitted to the LTCH on 9/2, 9/3, or 9/4. If the patient is readmitted to the LTCH on 9/5, payment will be paid to, for example, the acute care hospital which provided treatment, but the day count for determining whether the or not the stay is one interrupted stay or a whether the return to the LTCH is a separate admission starts on 9/2. For example, if the LTCH discharges a patient to an acute care hospital on 9/2/04, if they are readmitted to the LTCH by 9/10/04, this is an interrupted stay. If they are readmitted on 9/11/04, it counts as a separate admission. An interrupted stay case is treated as one discharge for the purposes of payment; only one LTCH PPS payment is made. (The bill generated by the original stay in the LTCH should be cancelled by the provider or they may do a debit/credit adjustment.)

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility.

If the length of stay at the "receiving" site of care exceeds the above- specified period of time, the return to the LTCH is a new admission. This means that the original discharge to that site is treated as a discharge for payment purposes.

For the percentage of payments that are to be made under the TEFRA system during the 5-year transition, the FI treats each segment of the interrupted stay as a separate discharge. (FIs are to follow the same procedure as provided under the IRF PPS in determining the amount of the payment under the blend that TEFRA would have paid.)

#### **150.9.1.4 - Payment Policy for Co-Located Providers**

*(Rev. 981, Issued: 06-15-06; Effective: 07-01-06; Implementation: 07-03-06)*

Hospitals within hospitals (HwH), satellite facilities, and onsite SNFs:

The LTCHs that are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs) are subject to the interrupted stay policy (§150.9.1.2) but in addition, if such discharges and readmissions exceed 5 percent of the LTCH's total discharges during a cost reporting period, **all** such readmissions during that cost reporting period are to be paid as one discharge, regardless of the time spent at the intervening facility.

- One 5 percent calculation is applied to discharges to and readmissions from onsite acute care hospitals and a separate 5 percent calculation is made for the combined discharges to, and readmissions to, the LTCH from onsite IRFs, SNFs, and psychiatric facilities.)
- Prior to triggering either of the 5 percent thresholds, such cases are to be evaluated and paid under the interrupted stay policy. (Presently, there is no interrupted stay policy for psychiatric facilities, so in the case of a LTCH patient who is directly readmitted from a psychiatric facility, there will be two LTC-DRG payments unless, and until, the number of such readmissions (counted along with readmissions from an onsite IRF or SNF) reach the 5 percent threshold.)

The LTCHs were required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that began on or after October 1, 2002. A change in co-located status must be reported to the FIs within 60 days of such a change. The implementation of the onsite policy is based on information maintained by FIs on other Medicare providers co-located with LTCHs. FIs notify the CMS RO of such arrangements.

Payments under this policy are determined at cost report settlement.

*Beginning FY 2005, an additional payment adjustment was established for LTCH HwHs and satellites of HwHs relating to the percentage of patients discharged during a specific cost reporting period that were admitted from their host hospital.*

### ***Basic payment formula***

- *If a LTCH HwH's admissions from its host hospital exceed 25 percent or the applicable percentage) of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS.*
- *In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)*

*An amount that is equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would be based on the standardized amount adjusted by the applicable IPPS DRG weighting factors.. This amount would be further adjusted for area wage levels using the applicable IPPS labor-related share based on the CBSA where the LTCH is physically located and the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. For LTCHs located in Alaska and*

*Hawaii, this amount would also be adjusted by the applicable COLA factors used under the IPPS. Furthermore, an amount equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would also include, where applicable, a DSH adjustment and where applicable, an IME adjustment.*

*Additionally, to arrive at the payment amount equivalent to what would otherwise be payable under the IPPS, a LTCH would also be paid under the LTCH PPS for the costs of inpatient capital-related costs, using the capital Federal rate determined under adjusted by the applicable IPPS DRG weighting factors This amount would be further adjusted by the applicable geographic adjustment factors set forth, including local cost variation (based on the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule), large urban location, and COLA, if applicable.*

*For discharges governed by this payment, an amount that is equivalent to an amount that would otherwise be paid under the IPPS for the inpatient capital-related costs would also include a DSH adjustment if applicable, and an equivalent IME adjustment), if applicable.*

*An amount equivalent to what would be paid under the IPPS would be determined based on the sum of the amount equivalent to what would be paid under the IPPS inpatient operating services and the amount equivalent to what would be paid under the IPPS for inpatient capital-related costs. This is necessary since, under the IPPS, there are separate Medicare rates for operating and capital costs to acute care hospitals, while under the LTCH PPS, there is a single payment rate for the operating and capital costs of the inpatient hospital's services provided to LTCH Medicare patients.*

*Note that there is a difference between the policy that we have codified for adjusted payments to LTCH HwHs and satellites of LTCHs which is based on an amount "equivalent" under the existing payment, and the additional component to the SSO payment adjustment that is based on an amount "comparable" to what would otherwise be paid under the IPPS adjustment.. The distinction is that if a SSO case also qualifies as a high cost outlier (HCO) case after the SSO payment amount is determined, the SSO payment formula uses the LTCH PPS fixed loss amount. In contrast, under the payment adjustment for LTCH HwHs and LTCH satellites if the amount payable by Medicare for a specific case is equivalent to what would be otherwise payable under the IPPS and the case also qualified as a HCO, the outlier payment for this case would be based on the IPPS HCO policy because the resulting payment would then be more equivalent to what would have been payable under the IPPS. Similarly, if under this payment adjustment the lesser amount resulted in an "otherwise payable amount under the LTCH PPS," and the stay qualified as a HCO, Medicare would generate a HCO payment governed by the LTCH PPS fixed loss amount calculated under the LTCH PPS and if the estimated cost of the case exceeds the adjusted LTC-DRG plus a fixed loss amount under §412.525(a), the LTCH would receive an additional payment based on the LTCH PPS HCO policy.*

### ***Specific Circumstances***

- *For rural acute care hospitals with HwHs, instead of the 25 percent criterion, the majority, (i.e., at least 51 percent) of the patients would have to be from the hospitals other than the host. In addition, in determining the percentage of patients admitted from the host, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital.*
- *For urban single or MSA dominant hospitals, we would allow the HwH to admit from the host up to the host's percentage of total Medicare discharges in the MSA. A floor of 25 percent and a ceiling of 51 percent applied to this variation.*

### ***Transition Period***

*This payment adjustment will be phased-in over 4 years for existing LTCH HwHs and also for LTCHs-under-formation that satisfy the following two-prong requirement:*

- *On or before October 1, 2004 they have certification as acute care hospitals, under Part 489; and*
- *Before October 1, 2005 designation as a LTCH.*

*For purposes of full payment under the LTCH PPS during the transition period, the percentage of discharges from the LTCH HwH originating from the host hospital for each applicable cost reporting period, may not exceed the percentage of discharges during the hospital's cost reporting period during FY 2004 that were admitted from the host hospital.*

***Year 1*** -- (cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) a "hold harmless"

- *Payments will be made under the LTCH PPS but the percentage of LTCH HwH discharges originating from the host may not exceed the percentage for such patients established for cost reporting periods during FY 2004.*

***Year 2*** -- (cost reporting periods beginning on or after October 1, 2005 through September 30, 2006)

- *LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 75 percent.*
- *For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.*

*Year 3 -- (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)*

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 50 percent.*
- For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.*

*Year 4 -- (cost reporting periods beginning on or after October 1, 2007 through September 30, 2008)*

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent or the applicable percentage described for “specific circumstances above.”*
- For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.*

**When both policies apply:**

*If a patient discharged from a LTCH HwH or satellite was originally admitted from the host hospital and immediately prior to that admission to the host, the patient was being treated at the same LTCH HwH or LTCH satellite, both of the policies described in this section, the 5 percent on-site policy as well as the 25 percent policy are applicable. In such a case, the following procedures should be followed keeping in mind that the 5 percent rule affects number of discharges and the 25 percent rule affects payment.*

- The on-site 5 percent computation is first in order to determine the real number of discharges.*
- Focusing on the relationship between an acute host and a LTCH HwH/satellite, if the number of revolving door discharges between these two facilities exceeds 5 percent during a CR period, this policy will collapse the number of discharges within that CR period, halving the # of revolving door LTCH stays where the intervening stay exceeded the threshold and eliminating from consideration those host stays that were bracketed by two LTCH stays. All such stays for the entire cost reporting period will be paid as one LTCH PPS stay.*

*The next issue is to determine which of these stays will be paid an unadjusted LTCH PPS rate and which will be paid an amount equivalent to what would otherwise be paid under the IPPS. Cases prior to tripping the 25 percent threshold will be paid*

*the otherwise unadjusted LTCH PPS rate and those after the threshold that had not achieved outlier status at the host it will be paid based on the adjustment.*

- *Because of the 5 percent policy that collapsed the discharges from the LTCH, for purposes of the 25 percent policy, we are focusing on fewer discharges in total from the LTCH and we need to determine what percent of these discharges originated in the host so that we can apply the payment adjustment.*
- *BUT, in the event that the 5 percent is not tripped during that cost reporting period, each acute-->LTCH-->acute--> LTCH cycle, which will count as two LTCH discharges originating in the host for purposes of the 25% policy, since both the first and second LTCH admission were from the host.*

### **150.23.1 - Inputs/Outputs to Pricer**

***(Rev. 981, Issued: 06-15-06; Effective: 07-01-06; Implementation: 07-03-06)***

#### **Inputs**

- Provider Specific File Data; Fields-*1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 18, 19, 21, 22, and 25* (although this field refers to the operating cost/charge ratio, for LTCH, entered here will be a combined operating and capital cost/charge ratio). Effective July 1, 2005, FIs shall no longer populate fields 12, 13, or 14. Field 35 must be populated for all LTCHs. Fields 33 and 38 shall be populated if applicable. *Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required.* See the section "Determining the Cost-to-Charge Ratio" below for determining the cost/charge ratio.
- The facility-specific rate (Field 21) will be determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the LTCH PPS were not being implemented.
- Bill Data
  - Provider #
  - Patient Status
  - Covered Charges
  - Discharge Date
  - Length of Stay (LOS)
  - Covered Days
  - Lifetime Reserve Days (LTR)
  - DRG (from Grouper)

## Outputs

- PPS Return Code
- MSA/CBSA (CBSAs will be returned for discharges on or after July 1, 2005).
- Wage Index
- Average LOS
- Relative Weight
- Final Payment Amount
- DRG Adjusted Payment Amount
- Federal Payment Amount
- Outlier Payment Amount
- Payment Amount
- Facility Costs
- LOS
- Regular Days Used
- LTR Days Used
- Blend Year, 1-5
- Outlier Threshold
- DRG
- COLA
- Calculation Version Code
- National Labor Percent
- National Non-Labor Percent
- Standard Federal Rate
- Budget Neutral Rate

New Facility-specific Rate