

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 578

Department of Health &
Human Services

Center for Medicare
and

Medicaid Services

Date: JUNE 10, 2005

Change Request 3884

SUBJECT: Update-Long Term Care Hospital Prospective Payment System (LTCH PPS)Rate Year 2006

I. SUMMARY OF CHANGES: This CR updates the changes to LTCH PPS for Rate Year 2006. Of particular importance is the move from Metropolitan Statistical Areas to Core-Based Statistical Areas. All new rates will be updated in the LTCH Pricer 060.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : *Discharges on or after July 1, 2005

IMPLEMENTATION DATE : July 5, 2005

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.*

R/N/D	Chapter / Section / SubSection / Title
R	3/20.2.3.1/Provider Specific File
R	3/150.10/Facility Level Adjustments
R	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 2005 operating budgets.

IV. ATTACHMENTS:

Manual Instruction

Recurring Notification Form

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

Attachment – Recurring Update Notification

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SUBJECT: Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2006

I. GENERAL INFORMATION

A. Background: On October 1, 2002, we 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) 2006, (July 1, 2005 – June 30, 2006)

- The standard Federal rate is \$38,086.04.
- The fixed loss amount is \$10,501.00.
- The budget neutrality adjustment is 0 percent. (The PRICER payment amount will include the adjustment factor as 1.00.)
- Core-Based Statistical Area (CBSA) designations will be used for assigning a wage index value for discharges occurring on or after July 1, 2005. There will be no transition blend under LTCH PPS for conversion to the CBSA-based labor market areas.
- The wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2005 is 4/5th (80 percent). The wage index table within the Pricer will include three columns:
 - a 2/5th column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2004,
 - a 3/5th column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2005, and
 - a 4/5th column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2006.

These columns will be 2/5th, 3/5th, and 4/5th of the CBSA wage index, not the MSA wage index.

- The labor-related share is 72.885 percent.
- The non-labor related share is 27.115 percent.
- The short-stay outlier percentage for “subsection II” LTCHs is 165 percent for this 3rd transition year.

2. Provider Specific File (PSF) Updates

We are modifying the inputs to the Provider Specific File to include the following Date Elements:

- 33 Special Payment Indicator (this data element shall be left blank, unless a correction to the wage index is needed).
- 35 Actual Geographic Location CBSA (based on the county in which the LTCH is located; a cross-walk file is available on <http://www.cms.hhs.gov/providers/longterm/frnotices.asp> under the heading “LTCH PPS Final Rule: Annual Payment Rate Updates and Policy Changes (CMS-1483-F))
- 38 Special Wage Index (this data element shall be left blank, unless there is an input to data element 33).

At this time, we do not foresee data elements 33 or 38 being populated by fiscal intermediaries (FIs). Data element 35 will be populated by the CBSA code. If the CBSA code is not known, you must go to the website to determine the CBSA code based on the county where the facility resides.

The following data elements are no longer required: 12, Change Code Wage Index Reclassification, 13, Actual Geographic Location MSA, or 14, Wage Index Location MSA. We realize that data elements 12 and 14 were not populated because there was no wage index reclassification under LTCH PPS. We initially included those elements as a placeholder in case a wage index reclassification was implemented.

3. LTCH Notification Requirement

LTCHs and satellites of LTCHs must notify their FIs and CMS of the name, address, and provider number of any Medicare providers with whom they are co-located, including acute care hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, and Skilled Nursing Facilities (SNF) within thirty days of the start of their cost reporting period and whenever any change occurs during a cost reporting period. A co-located or onsite facility means a hospital, unit, or SNF that occupies space in a building used by another hospital or unit or in one or more buildings on the same campus (within 250 yards of the LTCH), as buildings used by another hospital or unit. The FI shall maintain and update records on facilities that are co-located. The purpose is for data collection of co-located facilities and for implementation of payment policies in 42 CFR 412.532 and 412.534.

II. BUSINESS REQUIREMENTS

“Shall” denotes a mandatory requirement

“Should” denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)					
		F	R	C	D	Shared System Maintainers	O

						FISS	MCS	VMS	CWF
3884.1	FISS shall install and pay claims with LTCH PPS Pricer version 060, for discharges on or after July 1, 2005. This Pricer will include all Rate Year 2006 updates.					X			
3884.2	FIs shall update <u>all</u> LTCH PPS Provider Specific Files with a CBSA code for the July 2005 release.	X							
3884.3	The FI shall maintain and update records on facilities that are co-located.	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)							
		FI	RHI	Carrier	DMERC	Shared System Maintainers			
					FISS	MCS	VMS	CWF	
3884.4	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
3884.3 and Policy, section B3.	CMS Regional Offices shall identify a contact person for their FIs and LTCH providers.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements
3884.1	Please note that FISS shall load both the MSA file and a CBSA file with the Pricer release.

C. Interfaces: LTCH PPS Pricer

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: Discharges/through dates on or after July 1, 2005</p> <p>Implementation Date: July 5, 2005</p> <p>Pre-Implementation Contact(s): policy: Michele Hudson, michele.hudson@cms.hhs.gov and claims: Sarah Shirey, sarah.shirey-losso@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Appropriate Regional Office</p>	<p>No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.</p>
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20.2.3.1 - Provider-Specific File

(Rev. 578, Issued: 06-10-05; Effective: 07-01-05; Implementation: 07-05-05)

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](#).

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.

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

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

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

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.

D - Skilled Nursing Facility (SNF)

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. 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.

E - Home Health Agency (HHA)

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)

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 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type

G – Long Term Care Hospital (LTCH)

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 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 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.*

H – Inpatient Psychiatric Facilities (IPF)

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. 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, 3, 4, 5, 6, 7, 8, 10, 13, 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.

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,BLKSZ=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.

150.10 - Facility-Level Adjustments

(Rev. 578, Issued: 06-10-05; Effective: 07-01-05; Implementation: 07-05-05)

Facility-level adjustments are based on individual LTCH characteristics. The BIPA confers broad authority on the Secretary to include "appropriate adjustments to the long-term hospital payment system."

Variables examined include an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME).

- The system includes an area wage adjustment that is being phased in over 5 years.
- The wage adjustment is made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.
- A LTCH's wage index is based on the Metropolitan Statistical Area (MSA) or rural area in which the hospital is physically located, without regard to geographic reclassification under [§§1886\(d\)\(8\) - \(10\)](#) of the Act. *Effective July 1, 2005, an LTCH wage index is based on the Core-Based Statistical Area (CBSA).*
- The phase-in of the wage index adjustment is as follows:

Cost Reporting Periods Beginning During	Applicable Wage Index Value
FY 2003	1/5 th of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2004	2/5 ^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2005	3/5 ^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2006	4/5 ^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2007	Full value (5/5 ^{ths}) of the value of the applicable pre-reclassification, no floor hospital inpatient wage index

Based on analyses of patient charge data from FYs 2000 and 2001 MedPAR data and cost report data from FY 1998 and 1999 HCRIS data, there is no empirical evidence to support other adjustments. Therefore, for the present, there are no adjustments for DSH, IME, or geographic reclassification.

There is a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii.

- The adjustment is made by multiplying the nonlabor-related portion of the unadjusted standard Federal rate by the applicable COLA factor from OPM based on the county that the LTCH is located (similar to the COLA under the acute care hospital inpatient PPS).
- Annual updates for the LTCH PPS appear in **Federal Register** publications: for payment rates and associated adjustments, see the LTCH PPS final rule with an effective date of July 1. Annual updates of the LTC-DRGs are published in the IPPS final rule with an effective date of October 1.
- The COLA factors effective July 1, 2004 are the same as under the Acute Care Hospital Inpatient PPS and are as follows:

Area	COLA
Alaska:	
All Areas	1.25
Hawaii:	
Honolulu	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

150.23.1 - Inputs/Outputs to Pricer

(Rev. 578, Issued: 06-10-05; Effective: 07-01-05; Implementation: 07-05-05)

Inputs

- Provider Specific File Data; Fields-3,4,5,6,7,8,9,10,12,13,14,19 (five year blend or may choose 100%), 21,22,25 (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.* 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