CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1268	**Date: JUNE 15, 2007**
	Change Request 5652

SUBJECT: Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2008

I. SUMMARY OF CHANGES: 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. 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. Effective for cost reporting periods beginning on or after July 1, 2007, the payment adjustment that governs LTCH HwHs and satellites of HwHs discharging patients from their host hospital was extended to govern discharges from all LTCHs (not already addressed by the existing policy) that are admitted from any referring hospital.

New / Revised Material
Effective Date: * Discharges on or after July 1, 2007
Implementation Date: July 2, 2007

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	3/150/9.1.1 Short-Stay Outliers
R	3/150/9.1.4 Payment Policy for Co-Located Providers

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Manual Instruction
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1268	Date: June 15, 2007	Change Request: 5652

SUBJECT: Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2008

Effective Date: Discharges on or after July 1, 2007

Implementation Date: July 2, 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:

PRICER Updates: For LTCH PPS rate year (RY) 2008, (July 1, 2007 – June 30, 2008)

- The standard Federal rate is $38,356.45.
- The fixed loss amount is $20,738.
- 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^{ths} (100 percent). The wage index table within the PRICER will include two columns:
  - a 4/5^{ths} column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2006, and
  - a 5/5^{ths} column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2007.
- The labor-related share is 75.788 percent.
- The non-labor related share is 24.212 percent.

Short Stay Outlier (SSO) Updates: The existing payment adjustment formula for short-stay outlier cases was revised for those cases where the patient's LTCH LOS is less than, or equal to an "IPPS-comparable" threshold. For cases falling within this "IPPS-comparable" threshold, Medicare payments under the SSO policy will be subject to an additional adjustment.

The IPPS-comparable threshold is defined as a length of stay at the LTCH that is less than, or equal to, the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY 2008 final rule (72 FR 26870 at 27019- 27029).

If the LOS at the LTCH is within the IPPS-comparable threshold, Medicare payment will be based on an IPPS per diem amount, capped at the full IPPS comparable amount. This option would replace the "blend" amount and become part of the adjusted LTCH PPS payment formula.

Effective for discharges occurring on or after July 1, 2007, therefore, the adjusted Medicare payment for a case where LOS at the LTCH is within the IPPS-comparable threshold 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
- the "IPPS comparable" per diem amount , capped at the full IPPS comparable amount

The IPPS comparable amount will be determined by the same methodology as the IPPS comparable portion of the blend alternative, specified above in the above examples, at 2a.

For short-stay outlier cases where the length of stay exceeds the "IPPS threshold," payment would be made under the existing short-stay outlier policy, specified above.

Cost of Living Adjustment Updates (COLA): LTCH PPS incorporates a COLA as part of the operating and capital payments in LTCH PPS. New COLAs were implemented as part of the LTCH Final Rule for RY 2008. See the table below for the changed values.

Table of Cost-of-Living Adjustment Factors
Alaska Hospitals

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/	DM	FI	CA	DM	RH	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
5652.1	FISS shall install and pay claims with LTCH PPS PRICER Version 080 for discharges on and after July 1, 2007. This PRICER includes all Rate Year 2008 Updates.							X				
5652.2	Contractors shall update the provider specific file (PSF) with the new COLA values effective 7/1/07.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5652.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive 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. 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.	X		X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5652.1	Two new Pricer return codes are added to the software which describe the new portions of the SSO policy. They are: 26 and 27. There is no standard systems action for these codes.

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Policy: Michele Hudson at (410) 786-5490 or Judy Richter at (410) 786-2590.
Claims Processing & PRICER: Valeri Ritter at (410) 786-8652 or Sarah Shirey-Losso at (410) 786-0187

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),*** **use only one of the following statements:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC),*** **use the following statement:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

150.9.1.1 - Short-Stay Outliers

(Rev. 1268, Issued: 06-15-07, Effective: 07-01-07, Implementation: 07-02-07)

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 LTCDRG 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 (1/5th 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:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	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	$\frac{\$38,597.41}{33.6 \text{ days}}$ x11 days x 1.2	$15,163.27
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days	11 days ÷ 25 days	0.44
1c	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
2a	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	$\frac{\$8,019.82}{4.5 \text{ days}}$ x 11 days	$19,604.00
2b	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
2c	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 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 – 0.44	0.56

2d	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
3	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 5/6th 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:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	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	$38,597.41 x 27 days 33.6 days x 1.2	$37,218.93
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th 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 days ÷ 25 days is > 1; therefore percent is 1.00	1.00
1c	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 x $37,218.93	$37,218.93

2a	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	$\frac{\$8,019.82}{4.5 \text{ days}} \times 11$ days	$48,118.92
2b	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
2c	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 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 – 1.00	0.00
2d	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 x $8,019.82	$0.00
3	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**

* 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.

For RY 2008, the SSO policy was revised as follows:

The existing payment adjustment formula for short-stay outlier cases was revised for those cases where the patient's LTCH LOS is less than, or equal to an "IPPS-

comparable" threshold. For cases falling within this "IPPS-comparable" threshold, Medicare payments under the SSO policy will be subject to an additional adjustment.

The IPPS-comparable threshold is defined as a length of stay at the LTCH that is less than, or equal to, the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY 2008 final rule (72 FR 26870 at 27019- 27029).

If the LOS at the LTCH is within the IPPS-comparable threshold, Medicare payment will be based on an IPPS per diem amount, capped at the full IPPS comparable amount. This option would replace the "blend" amount and become part of the adjusted LTCH PPS payment formula.

Effective for discharges occurring on or after July 1, 2007, therefore, the adjusted Medicare payment for a case where LOS at the LTCH is within the IPPS-comparable threshold, 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*
- *the "IPPS comparable" per diem amount , capped at the full IPPS comparable amount*

The IPPS comparable amount will be determined by the same methodology as the IPPS comparable portion of the blend alternative, specified above in the above examples, at 2a.

For short-stay outlier cases where the length of stay exceeds the "IPPS threshold," payment would be made under the existing short-stay outlier policy, specified above.

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 or120 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%**.

150.9.1.4 - Payment Policy for Co-Located Providers

(Rev. 1268, Issued: 06-15-07, Effective: 07-01-07, Implementation: 07-02-07)

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 60days 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. *Effective for cost reporting periods beginning on or after July 1, 2007, the payment adjustment that governs LTCH HwHs and satellites of HwHs discharging patients from their host hospital was extended to govern discharges from all LTCHs (not already addressed by the existing policy)that are admitted from any referring hospital. This policy adjustment includes discharges from "grandfathered" LTCH HwHs and LTCH satellites that were admitted from their host hospitals; LTCH and LTCH satellite discharges from referring hospitals that are not co-located with the discharging facility; and discharges from "free-standing" LTCHs that were admitted from any referring hospital.*

Basic Payment Formula under the 25 Percent Threshold Payment Adjustment for Medicare Discharges from Referring Hospitals

- ***Admitted to co-located LTCHs and LTCH satellites from their host hospitals***

  - *This policy was finalized for FY 2005*

  o 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.

  o 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.)

- ***Admitted to Grandfathered LTCH HwHs and LTCH Satellites from their Host Hospitals***

  - *This policy is effective for RY 2008.*

  - *If a grandfathered 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.)*

- ***Admitted to all LTCHs and LTCH Satellites from Referring Hospitals other than those with which they are Co-located:***

  - *This policy is effective for RY 2008.*

  - *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 *(applicable to all of the above scenarios)*

• For *LTCH sand LTCH satellites located in* rural *areas*, instead of the 25 percent *threshold, we provide for a 50 percent threshold for patients from any individual referral hospital.* In addition, in determining the percentage of patients admitted from *that referring hospital*, 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 *referring hospitals*, we would allow the *LTCH or LTCH satellite* to admit from the host up to the *referring hospital'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*s*

For Medicare discharges from referring hospitals:

- ***Admitted to co-located LTCHs and LTCH satellites from their host hospitals***
    - *This policy was finalized for FY 2005.*

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.

Transition Period for all LTCHs affected by the Above Described Regulatory

The full payment threshold adjustment will be phased in over 3-years as follows:

Year 1—(*for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008)*

- *LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 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 2 *–(for cost reporting periods on or after July 1, 2008 through June 30, 2009),*

- *LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 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 3- *(for cost reporting periods on or after July 1, 2009)*

- *All LTCHs and LTCH satellites subject to the payment threshold policy effective for RY 2008, will be subject to the 25 percent (or applicable percentage) threshold.*

- *For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above*

Implementation:

- *The payment threshold policy for discharges from co-located LTCH HwHs and LTCH satellites admitted from their hosts (including grandfathered LTCH HwHs and satellites) is determined based on a location-specific basis.*
- *The payment threshold policy for discharges from LTCHs and LTCH satellites admitted from referring hospitals with which they are not co-located is determined based upon provider numbers for both the LTCH and the referring hospital.*

For LTCHs and LTCH satellites subject to both the FY 2005 and the RY 2008 threshold payment adjustment policies

- *If a co-located LTCH or a co-located referring hospital (host) shares a provider number with a hospital or satellite at another location, threshold determinations will continue to be location-specific for the co-located LTCH and host. The threshold percentage determinations will be applied to all other location or campus of either a LTCH or referring hospital in the aggregate. For example, when the policy finalized for RY 2008 is fully phased in, a co-located LTCH (LTCH A) and host (referring hospital A) will have a 25 percent threshold under the policy finalized for FY 2005. If referring hospital A shares a provider number with a remote location (RH A'), then another 25 percent threshold will be applied to patients discharged from LTCH A that were admitted RH A'.*

- *We note that for cost reporting periods beginning on or after October 1, 2007, non-grandfathered co-located LTCHs, are fully phased-in to the full 25 percent (or applicable percentage threshold) for discharges admitted from their co-located hosts (under the initial 25 percent payment threshold established for FY 2005)s.*

- *However, for discharges admitted from non-co-located referring hospitals, these LTCH HwHs and satellites are governed by the policy finalized for RY 2008. Therefore, for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008, the 75 percent threshold will apply, and the 50 percent threshold will apply for cost reporting periods beginning on or after July 1, 2008 through June 30, 2009 as described above in this response.)*

- *Furthermore, under our finalized policy for RY 2008, grandfathered LTCH HwHs and satellites will be subject to the 3-year transition that we are finalizing under this new policy for all their discharges, both admitted from their co-located host and from other non-co-located referring hospitals.*

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.