CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4529	**Date: February 14, 2020**
	Change Request 11616

SUBJECT: Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment

I. SUMMARY OF CHANGES: The purpose of this Change Request is to prepare the Medicare claims processing systems to calculate the LTCH Prospective Payment System (PPS) payment when an LTCH is subject to the discharge payment percentage payment adjustment.

EFFECTIVE DATE: Cost reporting periods beginning on or after October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

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/TOC
R	3/150/150.5 - Payment Provisions Under LTCH PPS
R	3/150/150.9 - Payment Rate
R	3/150/150.9.1.1 - Short-Stay Outliers
R	3/150/150.9.1.4 - Payment Policy for Co-Located Providers
R	3/150/150.9.1.5 - High Cost Outlier Cases
N	3/150/150.10.2 - Discharge Payment Percentage (DPP) Payment Adjustment
R	3/150/150.28 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/Addendum A - Provider Specific File

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4529	Date: February 14, 2020	Change Request: 11616

SUBJECT: Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment

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I. GENERAL INFORMATION

A. Background: Beginning with LTCHs' Fiscal Year (FY) 2016 cost reporting periods, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' fee-for-service (FFS) discharges which received LTCH Prospective Payment System (PPS) standard Federal rate payment to the LTCHs' total number of Medicare discharges under 42 CFR Part 412, Subpart O. Medicare Administrative Contractors (MACs) shall continue to provide notification to the LTCH of its discharge payment percentage upon settlement of the cost report. MACs may use the form letter available on the Internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html to notify LTCHs of their discharge payment percentage.

The purpose of this Change Request is to prepare the Medicare claims processing systems to calculate the LTCH PPS payment when an LTCH is subject to the discharge payment percentage payment adjustment.

B. Policy: Section 1886(m)(6)(C) of the Act, as added by section 1206 of the Pathway for Sustainable Growth Reform (SGR) Act of 2013 (Pub. L. 113-67), imposes several requirements related to an LTCH's DPP. As defined by section 1886(m)(6)(C)(iv) of the Act, the term "LTCH discharge payment percentage" is a ratio, expressed as a percentage, of Medicare FFS discharges not paid the site neutral payment rate to total number of Medicare FFS discharges occurring during the cost reporting period. In other words, an LTCH's discharge payment percentage is the ratio of an LTCH's Medicare discharges that meet the criteria for exclusion from the site neutral payment rate (as described under § 412.522(a)), that is, discharges paid the LTCH PPS standard Federal payment rate, to an LTCH's total number of Medicare FFS discharges paid under 42 CFR Part 412, Subpart O during the cost reporting period. Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods beginning on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that is not at least 50 percent be informed of such a fact; and section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH's discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by section 1886(m)(6)(C)(iii) of the Act (i.e. the full IPPS comparable amount). This policy is implemented in the regulations at 42 CFR 412.522(d).

LTCHs are subject to the DPP payment adjustment based on not maintaining the requisite discharge payment percentage for cost reporting periods beginning on or after October 1, 2019. The payment adjustment will apply to all of a LTCH's discharges in each successive cost reporting after it is notified that the discharge payment percentage for its cost reporting period was calculated not to be at least 50 percent. For example, if the discharge payment percentage for its FY 2020 cost reporting period is not at least 50 percent (when calculated during its FY 2022 cost reporting period), the LTCH will be subject to the payment adjustment, applied to all discharges, for its FY 2023 cost reporting period (i.e., the first cost reporting period after its discharge payment percentage for a cost reporting period had been calculated to not have been at least 50 percent).

Medicare contractors shall continue to calculate and the discharge payment percentage (the ratio, expressed as a percentage, of the LTCHs' FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges) upon settlement of for all LTCHs using the existing policies and procedures. Medicare contractors shall also continue to notify an LTCH that its DPP is not at least 50 percent for cost reporting period, and that notification shall include a statement that the discharges in the LTCH's succeeding cost reporting periods will be subject to the DPP payment adjustment until the requirements for full reinstatement or probationary reinstatement are met, along with the effective date that the DPP payment adjustment will begin.

For cost reporting periods subject to the DPP payment adjustment, the payment for all discharges (that is, both LTCH PPS standard Federal payment rate and site neutral; payment rate discharges) is an amount equivalent to the Inpatient Prospective Payment System (IPPS) amount, including any additional payment for high cost outlier cases based on the IPPS fixed-loss amount in effect at the time of the LTCH discharge (see § 412.522(d)(4)). The amount equivalent to the IPPS amount is determined under §§ 412.529(d)(4)(i)(A), and (d)(4)(ii) and (iii), which is the basis of the "IPPS comparable *per diem* amount" used to calculate short-stay outlier payments and site neutral payment rate payments. (That is, the amount equivalent to the IPPS amount under the DPP payment adjustment is the "full" IPPS comparable amount and not the per diem.) The DPP payment adjustment will be calculated by the LTCH PPS Pricer for all LTCH's discharges in cost reporting periods subject to the adjustment. The LTCH PPS Pricer will use a new LTCH DPP Indicator field in the Provider Specific File (PSF) to indicate whether the LTCH is subject to the DPP payment adjustment for a given period. Medicare contractors shall review the LTCH DPP Indicator field to ensure that it correctly reflects whether or not the LTCH is subject to the DPP payment adjustment effective for discharge in a given cost reporting period, including for the discontinuation of the DPP payment adjustment under the reinstatement processes provided in the regulations at 42 CFR 412.522(d)(5) and (6)(i), as well as for the application of the DPP payment adjustment during settlement when an LTCH fails to meet the requirements of the special probationary reinstatement at the end of the cost reporting period in which the DPP payment adjustment would have otherwise applied (see 42 CFR 412.522(d)(6)(ii)).

Under the full reinstatement process at 42 CFR 412.522(d)(5), the DPP payment adjustment for an LTCH's discharges will be discontinued with the discharges occurring in the cost reporting period after the LTCH's discharge payment percentage is calculated to be at least 50 percent. For example, an LTCH that did not have a discharge payment percentage of at least 50 percent during its FY 2020 cost reporting period will be subject to the DPP payment adjustment for all of the discharges occurring during its FY 2023 cost reporting period. However, if the discharge payment percentage for its FY 2021 cost reporting period equals at least 50 percent, the calculation (and notification thereof) of such percentage would be made during FY 2023, and the payment adjustment will be discontinued beginning with discharges occurring at the start of its FY 2024 cost reporting period. We note that this policy is based on cost reporting periods, is cyclical in nature, and, as such, an LTCH that has been reinstated would be subject to the DPP payment adjustment again (in a future cost reporting period) if its discharge payment percentage is again calculated not to meet the required threshold.

The special reinstatement process at 42 CFR 412.522(d)(6), includes a probationary cure period under which an LTCH may have the payment adjustment delayed during the applicable cost reporting period if, for the period of at least 5 consecutive months of the 6-month period immediately preceding the beginning of the cost reporting period during which the adjustment would apply, the discharge payment percentage is calculated to be at least 50 percent. (We note, this "cure period" is consistent with the current policy for the average length-of-stay determination at 42 CFR 412.23(e)(3)(iii).) Under such circumstances, the LTCH will not ultimately be subject to the payment adjustment for the cost reporting period during which the adjustment would have otherwise applied as long as the discharge payment percentage for *that cost reporting period* is at least 50 percent. If the discharge payment percentage for *that cost reporting period* is not at least 50 percent, the DPP payment adjustment will be applied to all the discharges that occurred in that cost reporting period at settlement.

For example, an LTCH with a calendar year cost reporting period that does not have a discharge payment percentage of at least 50 percent during its FY 2020 cost reporting period would be informed of this during

its FY 2022 cost reporting period. The DPP payment adjustment would then apply during its FY 2023 cost reporting period. However, if in the 6-month period immediately preceding the cost reporting period for which the payment adjustment would apply (July 1, 2022 through December 31, 2022), the LTCH had a discharge payment percentage of at least 50 percent for at least 5 consecutive months of that 6-month period, application of the DPP payment adjustment will be delayed during the FY 2023 cost reporting period (that is, the DPP payment adjustment will not be applied to any discharges that occur during the FY 2023 cost reporting period). However, if the discharge payment percentage that is ultimately calculated for that FY 2023 cost reporting period (the period for which the DPP payment adjustment would have applied if the LTCH had not met the requirements during the probationary cure period) is not at least 50 percent, at cost report settlement the payment adjustment delay will be lifted, and the DPP payment adjustment will be applied to payments made for all of the LTCH's discharges that occurred during the FY 2023 cost reporting period.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11616.1	Medicare contractors shall continue to calculate the discharge payment percentage (the ratio, expressed as a percentage, of the LTCHs' FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges) upon settlement of all LTCHs using the existing policies and procedures regardless of the new LTCH DPP Indicator in the Provider Specific File (PSF).	X								
11616.2	Medicare contractors shall continue to send notification to the LTCH that its DPP is not at least 50 percent during its cost reporting period.	X								
11616.2.1	In the notification, Medicare contractors shall include a statement that the discharges in the LTCH's succeeding cost reporting periods will be subject to the DPP payment adjustment until the requirements for full reinstatement or probationary reinstatement are met, and specify the effective date that the DPP payment adjustment will be effective. NOTE: Timeline examples provided in attachment.	X								
11616.2.2	Medicare contractors shall send the notification during the same cost reporting period in which the discharge payment percentage calculation in requirement 1 is performed to ensure that the requirement for the DPP payment adjustment to be applied to the LTCH's discharges in each successive cost reporting is met.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11616.3	Medicare contractors shall create a new alpha numeric field titled LTCH DPP Indicator in the Provider Specific File (PSF) to indicate whether the LTCH is subject to the DPP payment adjustment for failure to maintain the required discharge payment percentage. Valid values are: • Blank - LTCH is not subject to the DPP payment adjustment. • Y - LTCH is subject to the DPP payment adjustment.					X				
11616.4	Medicare contractors shall apply a maintenance edit when the LTCH DPP Indicator 'Y' is present in the PSF on other than an LTCH hospital (XX-2000 through XX-2299).					X				
11616.5	Medicare contractors shall update applicable inpatient reports with the new LTCH DPP Indicator field. (Ex. Reports 710, 964 and 967)					X				
11616.6	Medicare contractors shall modify its interface with the LTCH PRICER to accommodate the one-byte LTCH DPP Indicator field.					X				LTCH Pricer
11616.7	Medicare contractors shall pass the one-byte LTCH DPP Indicator to the LTCH PRICER.					X				LTCH Pricer
11616.8	CMS shall expand the LTCH PRICER input record to accept a one byte LTCH DPP Indicator.									LTCH Pricer
11616.8.1	When a 'Y' is present in the LTCH DPP Indicator field in the PSF, CMS shall update the LTCH PRICER to calculate a new payment amount, LTCH DPP adjustment amount, as the amount equivalent to the IPPS amount (ie., the full IPPS comparable amount minus the payment amount that would have been paid in the absence of the 'Y' being present in the LTCH DPP Indicator field in the PSF.									LTCH Pricer
11616.8.1.1	To calculate the final claim payment amount, CMS shall update the LTCH PRICER to add the LTCH DPP adjustment amount to the existing computation of the PPS-FINAL-PAY-AMT.									LTCH Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Example 1: LTCH DPP Adj. reduces payment to a Standard case COMPUTE PPS-FINAL-PAY-AMT = $1,350 PPS-STANDARD-FULL-PMT + $1200 PPS-STANDARD-SSO-PMT + 0 PPS-SITE-NEUTRAL-COST-PMT + 0 PPS-SITE-NEUTRAL-IPPS-PMT + $0 PPS-OUTLIER-PAY-AMT + $300 LTCH DPP adjustment -$150 Example 2: LTCH DPP adj increases payment to a SN case COMPUTE PPS-FINAL-PAY-AMT = $1,000 PPS-STANDARD-FULL-PMT + 0 PPS-STANDARD-SSO-PMT + 0 PPS-SITE-NEUTRAL-COST-PMT + 0 PPS-SITE-NEUTRAL-IPPS-PMT + $700 PPS-OUTLIER-PAY-AMT + $225 LTCH DPP adjustment +$75									
11616.8.2	Medicare contractors shall create a claim level field for inpatient claims, in the format S9(9)V99, to display the new LTCH DPP adjustment amount. Note: The LTCH DPP adjustment amount can be positive or negative and will be carried on the HUIP (Inpatient) transmit record to CWF, FPS, Physical Inpatient record, HIMR for INPH, Internal Testing Facility (ITF) and NCH.					X	X		X	FPS, MBD, NCH, NGD
11616.8.2.1	Medicare contractors shall modify the interface to pass the new LTCH DPP adjustment amount field to CWF and to downstream systems.					X			X	FPS, IDR, NCH, PS&R
11616.8.3	LTCH PRICER shall modify the interface with FISS to accommodate the new LTCH DPP adjustment amount.					X				IDR, LTCH Pricer
11616.8.4	The Medicare contractor shall add the new LTCH DPP adjustment amount field to the Lump Sum Utility.					X				PS&R
11616.9	LTCH PRICER shall pass the LTCH DPP adjustment amount to FISS.									LTCH Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11616.10	Medicare contractors shall receive a beta version of the July 2020 LTCH Pricer the week of March 1, 2020.									LTCH Pricer
11616.11	For LTCHs which did not have a discharge payment percentage of at least 50 percent during a cost reporting period, Medicare contractors shall calculate the LTCH's discharge payment percentage for the period of at least 5 consecutive months of the 6 months immediately preceding the LTCH's next cost reporting period (i.e., "cure period").	X								
11616.11.1	If the discharge payment percentage calculated for that "cure period" is *not* at least 50 percent, Medicare contractors shall update the LTCH DPP Indicator in the PSF with a 'Y' to indicate the LTCH is subject to the DPP payment adjustment with an effective date of the upcoming cost reporting period's begin date.	X								
11616.11.2	If the discharge payment percentage calculated for that "cure period" is at least 50 percent, Medicare contractors shall ensure the LTCH DPP Indicator in the PSF contains a 'blank' with an effective date of the upcoming cost reporting period's begin date until the discharge payment percentage for that cost reporting period can be calculated.	X								
11616.11.3	When Medicare contractors calculate the discharge payment percentage for that cost reporting period, if the discharge payment percentage for that period is *not* at least 50 percent, Medicare contractors shall update the PSF to indicate the DPP payment adjustment is applicable during that period by entering a 'Y' in the LTCH DPP Indicator with an effective date of that cost reporting period's begin date and shall reprocess inpatient hospital claims from an LTCH for all discharges in such cost reporting period.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11616.12	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, Cami.DiGiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

ATTACHMENTS: 1

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev.4529, Issued: 02- 14-2020)

Transmittals for Chapter 3

150.5 - Payment Provisions Under LTCH PPS
(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

Section 123 of Public Law 106-113(BBRA), as amended by §307 of Public Law 106-554(BIPA), authorizes the establishment of Federal payment rates under PPS for LTCHs. The BIPA confers broad authority on the Secretary to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case-level, to ensure that payment most accurately reflects cost.

The CMS has established a transition to full payments under the LTCH PPS: a 5-year phase-in during which a decreasing percentage of payments will based upon what payments would have been under the reasonable cost-based system. LTCHs may also elect to receive payment based on 100 percent of the "Federal payment rate." New LTCHs are to be paid based fully on 100 percent of the Federal rate (i.e. hospitals for which the first cost reporting period as an LTCH began on or after October 1, 2002). (See §150.10.1.)

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. This revision to LTCH PPS payments establishes two separate payment categories for LTCH patients upon discharge:

- *Standard LTCH PPS payment (i.e., the amount paid based on the MS-LTC-DRG) - LTCH cases meeting specific patient criteria*
- *Site neutral payment (i.e., the lesser of an "IPPS-comparable" payment amount or 100 percent of the estimated cost of the case) - those cases not meeting specific clinical criteria.*
  For cost reporting periods beginning between October 1, 2015 and September 30, 2019, discharges not meeting the specific patient criteria are paid using a blended payment amount equal to 50% the standard payment and 50% the site neutral payment for the discharge.

These requirements were implemented in the FY 2016 IPPS/LTCH PPS Final Rule beginning at 80 FR 49601. In order to be paid at the standard LTCH PPS payment amount one of the following patient criteria must be met:

1) the LTCH patient must have been admitted directly from a subsection (d) hospital (i.e., generally an IPPS hospital) during which at least 3 days were spent in an intensive care unit (ICU)as defined at 42 CFR 413.53(d), as determined by the presence of 020X and 021X revenue center codes on the claim, but the LTCH patient must not have a principal diagnosis of a psychiatric or rehabilitation diagnosis during the LTCH stay; or

2) the LTCH patient must have been admitted directly from a subsection (d) hospital (i.e., generally an IPPS hospital) and the LTCH patient must have received ventilator services of at least 96 hours during the LTCH stay,

generally determined by the presence of the ICD-10 code indicating 96 hours of ventilator services were provided, but must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis.

Section 231 of the Consolidated Appropriations Act, 2016 (Pub. L. 114-113), establishes a temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCHs. This exception applies for discharges occurring on or after April 21, 2016, and prior to January 1, 2017 from LTCHs "identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997" (which are a group of LTCHs commonly referred to as "grandfathered hospitals-within-hospitals" (HwHs)) and "located in a rural area" or "treated as being so located" pursuant to section 1886(d)(8)(E) of the Act when the individual discharged had "a severe wound"as defined in section 1886(d)(6)(E)(ii) of the Act. These requirements were implemented in an Interim Final Rule with Comment Period at 81 FR 23430, finalized in the FY 2017 IPPS/LTCH PPS Final Rule at 81 FR 57068.

ICD-10 diagnosis codes on the claim will be used to implement this temporary exception for certain wound care discharges. Six of the eight statutory categories included in the definition of "severe wound" are on the list of ICD-10 diagnosis codes found on the CMS web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html. "Payer-only" condition codes will be used for the remaining two "severe wound" statutory categories since they lack ICD-10 diagnosis codes with sufficient specificity to identify the presence of a "severe" wound. The remaining two "severe wound" categories are defined as:

1. *"wound with morbid obesity" - "a wound in those with morbid obesity that require complex, continuing care" and*
2. *"infected wound" - "a wound with infection requiring complex, continuing care."*

If a qualifying rural (or reclassified rural) LTCH grandfathered HwH LTCH has a discharge meeting this definition of "wound with morbid obesity" or "infected wound" the LTCH will inform its MAC, and the MAC will then place the payer-only condition code "M4" on the claim for processing which will generate a standard Federal payment for the claim (that is, exclusion from the site neutral payment rate).

Section 15010 of the 21st Century Cures Act (Pub. L. 114-255), establishes a separate temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCHs. This exception applies to discharges for cost reporting periods beginning between October 1, 2017 and September 30, 2018 from LTCHs "identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997" (which are a group of LTCHs commonly referred to as "grandfathered hospitals-within-hospitals" (HwHs)) when the individual discharged had "a severe wound"(as defined in section 1886(d)(6)(G)(ii) of the Act) and the discharge is classified under MS-LTC-DRG 539, 540, 602, or 603. Under this exception, in order to be considered a "severe wound" one of the ICD-10 diagnosis codes found on the CMS web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html must be on the claim. These requirements were implemented in the FY 2018 IPPS/LTCH PPS Final rule at 82 FR 38317.
Section 15009 of the 21st Century Cures Act (Pub. L. 114-255), establishes a separate temporary exception for all discharges from certain spinal cord specialty hospitals for discharges in cost reporting periods beginning between October 1, 2017 and September 30, 2019 from hospitals meeting the following criteria:

- *The hospital was a not-for-profit long-term care hospital on June 1, 2014, as determined by cost report data;*

- *Of the discharges in calendar year 2013 from the long-term care hospital for which payment was made under subpart O, at least 50 percent were classified under MS-LTC-DRGs 28, 29, 52, 57, 551, 573, and 963; and*

- *The long-term care hospital discharged inpatients (including both individuals entitled to, or enrolled for, benefits under Medicare Part A and individuals not so entitled or enrolled) during fiscal year 2014 who had been admitted from at least 20 of the 50 States determined by the States of residency of such inpatients.*

These requirements were implemented in the FY 2018 IPPS/LTCH PPS Final rule at 82 FR 38316.

150.9 - Payment Rate

(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

Payments to LTCHs under the LTCH PPS are based on a single standard Federal rate for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass through costs (i.e., bad debts, direct medical education, new technologies, and blood clotting factors). This single standard Federal rate is updated annually by the excluded hospital with capital market basket index. The formula for an unadjusted LTCH PPS prospective payment is as follows:

- Federal Prospective Payment = LTC-DRG Relative Weight * Standard Federal Rate Case-Level Adjustments

Effective July 1, 2003, the annual update to the standard Federal rate is based on the "LTCH PPS rate year" of July 1 through June 30, rather than the Federal fiscal year (October 1 through September 30). July 1, 2008, is the final rate year; LTCH PPS is moving back to a Federal Fiscal Year effective October 1, 2009.

Fiscal year changes to the LTCH PPS system occur annually in October. Specific instructions will be published shortly after the publication of the IPPS/LTCH PPS Final Rule each year. In addition, other changes to the LTCH PPS system may occur as necessary.

150.9.1.1 - Short-Stay Outliers

(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

- Generally, a short-stay outlier (SSO) is a case that has a covered 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. Effective for LTCH PPS discharges occurring on or before June 30, 2006, the adjusted payment for an SSO case is the least of:
  - 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio (CCR) 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 (1/5th 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 is 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 the 120 percent LTC-DRG per diem amount.

Under the blend alternative, the percentage of the 120 percent LTC-DRG per diem amount is 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 is 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) is 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	$\frac{\$38,597.41}{33.6 \text{ days}} \times 27 \text{ days} \times 1.2$	$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	$\frac{\$8,019.82}{4.5 \text{ days}} \times 11 \text{ days}$	$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

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
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 (i.e., full IPPS comparable amount) includes payment for the costs of inpatient operating services 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 includes a disproportionate share (DSH) adjustment (see §412.106), if applicable, and includes 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) are 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) are 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:

Effective for LTCH PPS discharges occurring on or after July 1, 2007, and on or before December 28, 2007*, the payment adjustment formula for SSO cases was revised for those cases where the patient's LTCH covered LOS is less than, or equal to an "IPPS-comparable" threshold. For cases falling within this "IPPS-comparable" threshold, Medicare payment under the SSO policy is subject to an additional adjustment.

The IPPS-comparable threshold is defined as 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 covered LOS at the LTCH is less than or equal to the IPPS-comparable threshold for the LTC-DRG, Medicare payment is based on the IPPS comparable per diem amount, capped at the full IPPS comparable amount. This option replaces the "blend" amount in the adjusted LTCH PPS SSO payment formula.

Effective for discharges occurring on or after July 1, 2007 and on or before December 28, 2007*, therefore, the adjusted Medicare payment for an SSO case where the covered LOS at the LTCH is within the IPPS-comparable threshold, is 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 is determined by the same methodology as the IPPS comparable portion of the blend alternative, specified above in the above examples at 2a.

For SSO cases where the covered length of stay exceeds the "IPPS threshold," payment is made under the SSO payment formula that became effective beginning in RY 2007, as specified above.

***NOTE:** On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the SSO payment adjustment formula for a 3-year period beginning on the date of enactment of the Act. Specifically, section 114(c)(3) of the MMSEA specifies that the revision to the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Consequently, the fourth option in the SSO payment adjustment formula at §412.529(c)(3)(i) will not apply during this 3-year period, and therefore, there will be no comparison of the covered LOS of the SSO case to the "IPPS threshold" in determining the payment adjustment for SSO cases. Therefore, for SSO discharges occurring on or after December 29, 2007, and before December 29, 2012, the adjusted payment for a SSO case is equal to 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 the 120 percent LTC-DRG per diem amount.

As noted above, during this 3-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the "IPPS threshold") are paid under the SSO payment formula that became effective beginning in RY 2007, as described above.

For FY 2018, the SSO policy was revised so that all SSO discharges are paid at the 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 the 120 percent LTC-DRG per diem amount, as described 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 returns to **120%**.

150.9.1.4 - Payment Policy for Co-Located Providers

(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

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

In accordance with 79 FR50189, prior to October 1, 2014, 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 A/B MACs (A) 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 A/B MACs (A) within 60days of such a change. The implementation of the onsite policy is based on information maintained by A/B MACs (A) on other Medicare providers co-located with LTCHs. A/B MACs (A) notify the CMS RO of such arrangements.

Payments under this policy are determined at cost report settlement.

150.9.1.5 - High Cost Outlier Cases

(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

Additional payments are made for those cases that are considered high cost outliers *for both LTCH PPS standard Federal rate discharges and site neutral discharges.* A case falls into this category if the estimated cost of the case exceeds the outlier threshold (the LTC-DRG payment plus a fixed loss amount). (Short-stay outliers, described above, are also eligible for outlier payments if their costs exceed the outlier threshold. The applicable short-stay outlier payment is used to determine the outlier threshold for short-stay outlier cases.)

*For LTCH PPS standard Federal rate discharges, t*he fixed loss amount is determined annually on July 1 such that projected outlier payments are equal to 8 percent of total LTCH PPS payments. July 1, 2008, is the final rate year; LTCH PPS is moving back to a Federal Fiscal Year effective October 1, 2009. *For fiscal years 2018 and later, the fixed-loss amount is determined such that the estimated proportion of outlier payments under paragraph (a) of this section payable for such discharges is projected to be equal to 99.6875 of 8 percent.*

If the estimated cost of the case is greater than the outlier threshold an additional payment is added to the LTC-DRG payment amount.

The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the LTC-DRG payment plus a fixed loss amount).

The estimated cost of the case is calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio obtained from the latest settled cost report.

For discharges occurring on or after August 8, 2003, (high cost outlier payments may 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).

A separate high cost outlier (HCO) fixed loss amount is calculated for site neutral discharges.

If the estimated cost of the case is greater than the outlier threshold an additional payment is added to the LTC-DRG payment amount.

The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the LTC-DRG payment plus a fixed loss amount).

The estimated cost of the case is calculated by multiplying the Medicare allowable charge on the claim by the LTCH's hospital-specific cost-to-charge ratio obtained from the latest settled cost report.

150.10.2 - Discharge Payment Percentage (DPP) Payment Adjustment
(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' fee-for-service (FFS) discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of Medicare FFS discharges.
Section 1886(m)(6)(C) of the Act, as added by section 1206 of the Pathway for SGR Reform Act of 2013 (Pub. L. 113-67), imposes several requirements related to an LTCH's discharge payment percentage (DPP).

For cost reporting periods beginning on or after October 1, 2019, an LTCH shall be informed when its discharge payment percentage for the cost reporting period is not at least 50 percent. All of the LTCH's discharges in each successive cost reporting period shall be paid the payment amount that would apply under subsection (d) for the discharge, if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by section 1886(m)(6)(C)(iii) of the Act (i.e. the full IPPS comparable amount). This policy is implemented in the regulations at 42 CFR 412.522(d). These requirements were implemented in the FY 2020 IPPS/LTCH PPS Final Rule at 84 FR 42439

150.28 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a LTCH is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via email to outliersIPPS@cms.hhs.gov and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total short stay and high cost outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office via email at outliersIPPS@cms.hhs.gov that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   *__NOTE__: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and

will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

7) Type of Bill (TOB) equals 11X
8) Previous claim is in a paid status (P location) within FISS
9) Cancel date is 'blank'

10) The Medicare contractor reconciles the claims through the applicable LTCH Pricer software and not through any editing or grouping software.

11) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

12) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

13) For hospitals paid under the LTCH PPS, the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility will reflect the difference between the total original short-stay and high cost outlier payment amount and the revised short-stay and high cost outlier payment amount. If the difference between the original and revised PPS Payment Amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised PPS Payment is negative, then a debit amount (deduction) shall be issued to the provider.

14) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §150.27. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a negative amount then the time value of money is also a negative amount. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original PPS Payment Amount and Revised PPS Payment Amount.

15) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original PPS amount by summing lines 1.02 and 1.05 from Worksheet E-3, Part I, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part I of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part I. For complete instructions on how to fill out these lines please see §3633.1 of the Provider Reimbursement Manual, Part II.

16) For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original PPS amount from Worksheet E-3, Part IV line 3, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part IV of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 20 of Worksheet E-3, Part IV.

17) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

18) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the LTCH PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 -Operating Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the Central Office, via email at outliersIPPS@cms.hhs.gov.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)

List of Data Elements for FISS Extract
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original LTCH DPP Adjustment Amount
Revised LTCH DPP Adjustment Amount
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

Addendum A - Provider Specific File

(Rev.4529, Issued: 02- 14-2020, Effective: 10-01-19, Implementation: 07-06-20)

Data Element	File Position	Format	Title	Description
1	1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character NPI number.

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the OSCAR number and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table></td></tr>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
Year: Greater than 82, but not greater than current year.
Month: 01-12
Day: 01-31</td></tr>
</table>

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital

Data Element	File Position	Format	Title	Description
				(during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). Eff. 10/1/12, this provider type no longer valid. 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).

Data Element	File Position	Format	Title	Description
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.

Data Element	File Position	Format	Title	Description
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all

Data Element	File Position	Format	Title	Description
				HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. 1 — Federal % 20 — Facility% 80 2 — Federal % 40 — Facility% 60 3 — Federal % 60 — Facility% 40 4 — Federal % 80 — Facility% 20 5 — Federal % 100 — Facility% 00 **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. 1 — Federal % 25 — Facility% 75 2 — Federal % 50 — Facility% 50 3 — Federal % 75 — Facility% 25 4 — Federal % 100 — Facility% 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.

Data Element	File Position	Format	Title	Description
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.

Data Element	File Position	Format	Title	Description
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for each HHA. If no factor is provided, enter 1.00000.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.

Data Element	File Position	Format	Title	Description
			Core-Based Statistical Area (CBSA)	
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a "1" or "2."
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero-fill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard

Data Element	File Position	Format	Title	Description
				deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter “Y” if participating in Hospital Value Based Purchasing. Enter “N” if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter “0” if not participating in Hospital Readmissions Reduction program. Enter “1” if participating in Hospital Readmissions Reduction program.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor. If Data Element 53 = “0”, leave blank.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a ‘Y’ if the hospital is subject to a reduction under the HAC Reduction Program. Enter a ‘N’ if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records	Enter a ‘Y’ if the hospital is subject to a reduction due to **NOT** being an EHR

Data Element	File Position	Format	Title	Description
			(EHR) Program Reduction	meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	*269-269*	*X*	*LTCH DPP Indicator*	*Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.*
63	*270-310*	*X(41)*	*Filler*	

LTCH DPP EXAMPLE TIMELINES:

LTCH with a Federal fiscal year cost reporting period:

1. FY 2020 cost reporting period is 10/1/2019 through 9/30/2020 (and all subsequent cost reporting periods are 12-months).
2. FY 2020 cost report submitted on or around 2/27/2021 (during the LTCH's FY 2021 cost reporting period) and final settled approximately 12 months later (during the LTCH's FY 2022 cost reporting period).
3. MAC **calculates DPP** at final settlement (on or around 2/27/2022) and **notifies provider of DPP** before 9/30/2022 (i.e., notification and calculation must occur during the same cost reporting period). (The cost reporting period for which the adjustment would apply (absent curing) is the LTCH's FY 2023 cost reporting period.)
    a. If the **DPP is at least 50%**, the payment adjustment is not applied for discharges occurring during the LTCH's FY 2023 cost reporting period (enter "blank" in the LTCH DPP Indicator in the PSF effective 10/1/2022).
    b. If the **DPP is not at least 50%**, the LTCH is entitled to a review of its DPP during the probationary cure period (at least 5 consecutive months of the period between 4/1/2022 through 9/30/2022).
        i. If the **cure period DPP is at least 50%**, application of the payment adjustment during the FY 2023 cost reporting period is suspended (enter a "blank" in the LTCH DPP Indicator in the PSF effective 10/1/2022).
        ii. If the **cure period DPP is not at least 50%**, the payment adjustment is applied for all discharges that occur during the FY 2023 cost reporting period (enter "Y" in the LTCH DPP Indicator in the PSF, effective 10/1/2022).
    c. If the **payment adjustment was suspended** based on the cure period review (in Step 3.b.i.), when the MAC reviews the LTCH's FY 2023 cost reporting period (following its settlement on or around 2/27/2025), **if the DPP for that FY 2023 cost reporting period is not at least 50%**, the payment adjustment **is applied** to ***all discharges*** that occur **during the FY 2023 cost reporting period**.
        i. To apply the payment adjustment to all of the LTCH's discharges that occurred during its FY 2023 cost reporting period, enter a "Y" in the LTCH DPP Indicator in the PSF, effective 10/1/2022 and reprocess all of the LTCH's claims for discharges that occur during its FY 2023 cost reporting period.
        ii. The DPP calculated for the FY 2023 cost reporting period will *also* be used to determine if the payment adjustment would apply (absent curing) for the LTCH's FY 2026 cost reporting period.

LTCH with a September 1st cost reporting period:

1. FY 2020 cost reporting period is 9/1/2020 through 8/31/2021 (and all subsequent cost reporting periods are 12-months).
2. FY 2020 cost report submitted on or around 1/28/2022 (during the LTCH's FY 2021 cost reporting period and final settled approximately 12 months later (during the LTCH's FY 2022 cost reporting period).
3. MAC **calculates DPP** at final settlement (on or around 1/30/2023) and **notifies provider of DPP** before 8/31/2023 (i.e., notification and calculation must occur during the same cost reporting period). (The cost reporting period for which the adjustment would apply (absent

curing) is the LTCH's FY 2023 cost reporting period. Claims reprocessing may be needed if there is not adequate time to update the PSF in time to process payments for discharges occurring on/after 9/1/2023.)

a. If the **DPP is at least 50%**, the payment adjustment is not applied for discharges occurring during the LTCH's FY 2023 cost reporting period (enter "blank" in the LTCH DPP Indicator in the PSF effective 9/1/2023).
b. If the **DPP is not at least 50%**, the LTCH is entitled to a review of its DPP during the probationary cure period (at least 5 consecutive months of the period between 3/1/2023 through 8/31/2023).
    i. If the **cure period DPP is at least 50%**, application of the payment adjustment during the FY 2023 cost reporting period is suspended (enter a "blank" in the LTCH DPP Indicator in the PSF effective 9/1/2023).
    ii. If the **cure period DPP is not at least 50%**, the payment adjustment is applied for all discharges that occur during the FY 2023 cost reporting period (enter "Y" in the LTCH DPP Indicator in the PSF 9/1/2023).
c. If the **payment adjustment was suspended based on the cure period review** (in Step 3.b.i.), when the MAC reviews the LTCH's FY 2023 cost reporting period (following its settlement on or around 1/30/2025), **if the DPP for that FY 2023 cost reporting period is not at least 50%**, the payment adjustment **is applied** to ***all discharges*** that occur **during the FY 2023 cost reporting period**.
    i. To apply the payment adjustment to all of the LTCH's discharges that occurred during its FY 2023 cost reporting period, enter a "Y" in the LTCH DPP Indicator in the PSF effective 9/1/2023 and reprocess all of the LTCH's claims for discharges that occur during its FY 2023 cost reporting period.
    ii. The DPP calculated for the FY 2023 cost reporting period will *also* be used determine if the payment adjustment would apply (absent curing) for the LTCH's FY 2026 cost reporting period.

LTCH with a 9 month (i.e., "short") cost reporting period:

1. Two cost reports begin during FY 2020: a cost reporting period of 10/1/2019 through 6/30/2020 and a cost reporting period of 7/1/2020 through 6/30/2021 and (and all subsequent cost reporting periods are 12-months beginning July 1st).
2. First FY 2020 cost report submitted on or around 11/30/2020 (during the LTCH's 7/1/2020 through 6/30/2021 cost reporting period) and final settled approximately 12 months later (during the LTCH's FY 2021 cost reporting period).
3. MAC **calculates DPP** at final settlement (on or around 11/30/2021) and **notifies provider of DPP** before 6/30/2022 i.e., (notification and calculation must occur during the same cost reporting period). (The cost reporting period for which the adjustment would apply (absent curing) is the LTCH's FY 2022 cost reporting period.)
    a. If the **DPP is at least 50%**, the payment adjustment is not applied for discharges occurring during the LTCH's FY 2022 cost reporting period (enter "blank" in the LTCH DPP Indicator in the PSF effective 7/1/2022).
    b. If the **DPP is not at least 50%**, the LTCH is entitled to a review of its DPP during the probationary cure period (at least 5 consecutive months of the period between 1/1/2022 through 6/30/2022).

i. If the **cure period DPP is at least 50%**, application of the payment adjustment during the FY 2022 cost reporting period is suspended (enter a "blank" in the LTCH DPP Indicator in the PSF effective 7/1/2022).

ii. If the **cure period DPP is not at least 50%**, the payment adjustment is applied for all discharges that occur during the FY 2022 cost reporting period (enter "Y" in the LTCH DPP Indicator in the PSF, effective 7/1/2022).

c. If the **payment adjustment was suspended** based on the cure period review (in Step 3.b.i.), when the MAC reviews the LTCH's FY 2022 cost reporting period (following its settlement on or around 11/30/2023), **if the DPP for that FY 2022 cost reporting period is not at least 50%**, the payment adjustment **is applied** to ***all discharges*** that occur **during the FY 2022 cost reporting period**.

i. To apply the payment adjustment to all of the LTCH's discharges that occurred during its FY 2022 cost reporting period, enter a "Y" in the LTCH DPP Indicator in the PSF, effective 7/1/2022 and reprocess all of the LTCH's claims for discharges that occur during its FY 2022 cost reporting period.

ii. The DPP calculated for the FY 2022 cost reporting period will *also* be used to determine if the payment adjustment would apply (absent curing) for the LTCH's FY 2025 cost reporting period.