

§ 412.532 Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.

(a) The policies set forth in this section apply in the following situations:

(1) A long-term care hospital (including a satellite facility) that is co-located within an onsite acute care hospital, an onsite IRF, or an onsite psychiatric facility or unit that meets the definition of a hospital-within-a-hospital under § 412.22(e).

(2) A satellite facility, as defined in § 412.22(h), that is co-located with the long-term care hospital.

(3) A SNF, as defined in section 1819(a) of the Act, that is co-located with the long-term care hospital.

(b) As used in this section, “co-located” or “onsite” facility means a hospital, satellite facility, unit, or SNF that occupies space in a building also used by another hospital or unit or in one or more buildings on the same campus, as defined in § 413.65(a)(2) of this subchapter, as buildings used by another hospital or unit.

(c) If, during a cost reporting period, a long-term care hospital (including a satellite facility) discharges patients to an acute care hospital co-located with the long-term care hospital, as described in paragraph (a) of this section, and subsequently directly readmits more than 5 percent (that is, in excess of 5.0 percent) of the total number of its Medicare inpatients discharged from that acute care hospital, all such discharges to the co-located acute care hospital and the readmissions to the long-term care hospital will be treated as one discharge for that cost reporting period and one LTC-DRG payment will be made on the basis of each patient’s initial principal diagnosis.

(d) If, during a cost reporting period, a long-term care hospital (including a satellite facility) discharges patients to an onsite IRF, an onsite psychiatric hospital or unit, or an onsite SNF, as described in paragraph (a) of this section, and subsequently directly readmits more than 5 percent (that is, in excess of 5.0 percent) of the total number of its Medicare inpatients discharged from the onsite IRF, the onsite psychiatric hospital or unit, or the onsite SNF, all such discharges to any of

these providers and the readmissions to the LTCH will be treated as one discharge for that cost reporting period and one LTC-DRG payment will be made on the basis of the patient’s initial principal diagnosis.

(e) For purposes of calculating the payment per discharge, payment for the entire stay at the long-term care hospital will be paid as a full LTC-DRG payment under § 412.523 or a short-stay outlier under § 412.529, depending on the duration of the entire stay.

(f) If the long-term care hospital does not meet the 5-percent thresholds specified under paragraph (c) or (d) of this section for discharges to the specified onsite providers and readmissions to the long-term care hospital during a cost reporting period, payment under the long-term care prospective payment system will be made, where applicable, under the policies on a 3-day or less interruption of a stay and a greater than 3-day interruption of a stay as specified in § 412.531.

(g) Payment to the onsite acute care hospital, the onsite IRF, the onsite psychiatric hospital or unit, and the onsite SNF for a beneficiary’s stay in the specified onsite providers is subject to the applicable payment policies, including outliers and transfers, under the acute care hospital inpatient prospective payment system, the IRF prospective payment system, the SNF prospective payment system, or the excluded psychiatric hospital or unit cost-based reimbursement payment system, as appropriate.

(h) In determining whether a patient has previously been discharged and then admitted, all prior discharges are considered, even if the discharge occurs late in one cost reporting period and the readmission occurs late in next cost reporting period.

(i)(1) A long-term care hospital or a satellite of a long-term care hospital that meets the criteria of § 412.22(e)(1) or (e)(2) or § 412.22(h)(1) through (h)(4) that occupies space in a building used by another hospital or in one or more entire buildings located on the same campus as buildings used by another hospital and must notify its fiscal intermediary and CMS in writing of its co-location and identify by name(s), address(es), and Medicare provider

§ 412.533

42 CFR Ch. IV (10–1–10 Edition)

number(s) the onsite acute care hospital, onsite IRF, or onsite psychiatric facility or unit with which it is co-located.

(2) A long term care hospital or satellite of a long term care hospital that occupies space in a building used by a SNF or in one or more entire buildings located on the same campus as buildings used by a SNF must notify its fiscal intermediary and CMS in writing of its co-located status and identify by name, address and Medicare provider number the SNF with which it is co-located.

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§ 412.533 Transition payments.

(a) *Duration of transition periods.* Except for a long-term care hospital that makes an election under paragraph (c) of this section or for a long-term care hospital that is defined as new under § 412.23(e)(4), for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, a long-term care hospital receives a payment comprised of a blend of the adjusted Federal prospective payment as determined under § 412.523, and the payment determined under the cost-based reimbursement rules under Part 413 of this subchapter.

(1) For cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003, payment is based on 20 percent of the Federal prospective payment rate and 80 percent of the cost-based reimbursement rate.

(2) For cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004, payment is based on 40 percent of the Federal prospective payment rate and 60 percent of the cost-based reimbursement rate.

(3) For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005, payment is based on 60 percent of the Federal prospective payment rate and 40 percent of the cost-based reimbursement rate.

(4) For cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006, payment is based on 80 percent of the Federal prospective payment rate and 20 percent of the cost-based reimbursement rate.

(5) For cost reporting periods beginning on or after October 1, 2006, payment is based entirely on the adjusted Federal prospective payment rate.

(b) *Adjustments based on reconciliation of cost reports.* The cost-based percentage of the provider's total Medicare payment under paragraphs (a)(1) through (a)(4) of this section are subject to adjustments based on reconciliation of cost reports.

(c) *Election not to be paid under the transition period methodology.* A long-term care hospital may elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition periods specified in paragraph (a) of this section. Once a long-term care hospital elects to be paid based on 100 percent of the Federal prospective payment rate, it may not revert to the transition blend.

(1) *General requirement.* A long-term care hospital must notify its fiscal intermediary of its intent to elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period specified in paragraph (a) of this section.

(2) *Notification requirement to make election.* (i) The request by the long-term care hospital to make the election under paragraph (c)(1) of this section must be made in writing to the Medicare fiscal intermediary.

(ii) For cost reporting periods that begin on or after October 1, 2002 through November 30, 2002, the fiscal intermediary must receive the notification of the election before November 1, 2002.

(iii) For cost reporting periods that begin on or after December 1, 2002 through September 30, 2006, the fiscal intermediary must receive the notification of the election on or before the 30th day before the applicable cost reporting period begins.

(iv) The fiscal intermediary must receive the notification by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section will not be