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(6) Any evidence that supports the inpatient psychiatric facility's reconsideration request, such as emails and other documents.

(c) An inpatient psychiatric facility that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

[77 FR 53678, Aug. 31, 2012, as amended at 86 FR 42678, Aug. 4, 2021]

Subpart O—Prospective Payment System for Long-Term Care Hospitals

SOURCE: 67 FR 56049, Aug. 30, 2002, unless otherwise noted.

§ 412.500 Basis and scope of subpart.

(a) *Basis.* This subpart implements the following:

(1) Section 123 of Public Law 106–113, which provides for the implementation of a prospective payment system for long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act.

(2) Section 307 of Public Law 106–554, which states that the Secretary shall examine and may provide for appropriate adjustments to that system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(3) Section 114 of Public Law 110–173, which contains several provisions regarding long-term care hospitals, including the—

(i) Amendment of section 1886 of the Act to add a new subsection (m) that references section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554 for the establishment and implementation of a prospective payment system for payments under title XVIII for inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Act; and

(ii) Revision of the standard Federal rate for RY 2008.

(4) Section 4302(a) of Public Law 111–5, which amended sections 114(c) and

(d) of Public Law 110–173 relating to several moratoria on the establishment of new long-term care hospitals and satellite facilities and on the increase in the number of beds in existing long-term care hospitals and satellite facilities under the long-term care hospital prospective payment system.

(5) Sections 3106(a) and 10312(a) of Public Law 111–148, which extended certain payment rules and moratoria under the long-term care hospital prospective payment system by further amending sections 114(c) and (d) of Public Law 110–173.

(6) Section 1206 of Public Law 113–67, which further extended certain payment rules and moratoria under the long-term care hospital prospective payment system by amending sections 114(c) and (d) of Public Law 110–173, and which:

(i) Added a new section 1886(m)(6) to the Act to establish a site neutral payment amount for long-term care hospital discharges that fail to meet the applicable criteria in cost reporting periods beginning on or after October 1, 2015; and

(ii) Requires the Secretary's review of the payment rates and regulations governing long-term care hospitals established under section 1886(d)(1)(B)(iv)(II) of the Act and application of payment adjustments based on that review.

(7) Section 411 of Public Law 114–10 which revises the annual update to the LTCH PPS standard Federal payment rate in FY 2018.

(8) Public Law 114–255 which at—

(i) Section 15004 amended the moratorium on increasing beds in existing LTCHs and LTCH satellite facilities and amended high cost outlier payment requirements;

(ii) Section 15006 amended moratoria on certain payment policies;

(iii) Section 15007 amended the average length of stay requirements;

(iv) Section 15009 temporally excepted certain spinal cord specialty hospitals from the site neutral payment rate; and

(v) Section 15010 temporally excepted certain wound care discharges from certain LTCHs from the site neutral payment rate.

(9) Section 51005(a) of Public Law 115–123 which extended the blended payment rate for the site neutral payment rate cases to apply to discharges occurring in cost reporting periods beginning in FYs 2018 and 2019.

(10) Section 51005(b) of Public Law which reduces the IPPS comparable amount for the site neutral payment rate cases by 4.6 percent for FYs 2018 through 2026.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for long-term care hospitals, including the methodology used for the development of payment rates and associated adjustments and related rules. Under this system, for cost reporting periods beginning on or after October 1, 2002, payment for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals is made on the basis of prospectively determined rates and applied on a per discharge basis.

[67 FR 56049, Aug. 30, 2002, as amended at 73 FR 24879, May 6, 2008; 79 FR 50355, Aug. 22, 2014; 82 FR 38512, Aug. 14, 2017; 83 FR 41704, Aug. 17, 2018]

§ 412.503 Definitions.

As used in this subpart—

CMS stands for the Centers for Medicare & Medicaid Services.

Discharge. A Medicare patient in a long-term care hospital is considered discharged when—

(1) For purposes of the long-term care hospital qualification calculation, as described in § 412.23(e)(3), the patient is formally released;

(2) For purposes of payment, as described in § 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

(3) The patient dies in the long-term care facility.

Long-term care hospital prospective payment system fiscal year means, beginning October 1, 2010, the 12-month period of October 1 through September 30.

Long-term care hospital prospective payment system payment year means the general term that encompasses both the definition of “long-term care hospital prospective payment system rate year” and “long-term care hospital prospective payment system fiscal year” specified in this section.

Long-term care hospital prospective payment system rate year means—

(1) From July 1, 2003 and ending on or before June 30, 2008, the 12-month period of July 1 through June 30.

(2) From July 1, 2008 and ending on September 30, 2009, the 15-month period of July 1, 2008 through September 30, 2009.

(3) From October 1, 2009 through September 30, 2010, the 12-month period of October 1 through September 30.

LTC-DRG stands for the diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes. Effective October 1, 2007, long-term care hospital patient discharges occurring on or after October 1, 2007, are classified by a severity-adjusted patient classification system, the MS-LTC-DRGs. Any reference to the term “LTC-DRG” shall be considered a reference to the term “MS-LTC-DRG” when applying the provisions of this subpart for policy descriptions and payment calculations for discharges from a long-term care hospital occurring on or after October 1, 2007.

MSA means a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

MSA-dominant area means an MSA in which an MSA-dominant hospital is located.

MSA-dominant hospital means a hospital that has discharged more than 25 percent of the total subsection (d) hospital Medicare discharges in the MSA (not including discharges paid by a Medicare Advantage plan) in which the hospital is located.

MS-LTC-DRG stands for the severity-adjusted diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes for discharges from a long-term care hospital occurring on or after October 1, 2007.

Outlier payment means an additional payment beyond the long-term care hospital standard Federal payment rate or the site neutral payment rate (including, when applicable, the blended payment rate), as applicable, for cases with unusually high costs.

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QIO (formerly PRO or Peer Review Organization) stands for the Quality Improvement Organization.

Rural area means—(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in § 412.62(f)(1)(iii);

(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an area as defined in § 412.64(b)(1)(ii)(C); and

(3) For discharges occurring on or after July 1, 2008, any area outside an urban area.

Subsection (d) hospital means, for purposes of § 412.522, a hospital defined in section 1886(d)(1)(B) of the Social Security Act and includes any hospital that is located in Puerto Rico and that would be a subsection (d) hospital as defined in section 1886(d)(1)(B) of the Social Security Act if it were located in one of the 50 States.

Urban area means—(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in § 412.62(f)(1)(ii);

(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an urban area means an area as defined in § 412.64(b)(1)(ii)(A) and (B); and

(3) For discharges occurring on or after July 1, 2008, a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

[67 FR 56049, Aug. 30, 2002, as amended at 72 FR 47412, Aug. 22, 2007; 73 FR 26838, May 9, 2008; 75 FR 50416, Aug. 16, 2010; 80 FR 49767, Aug. 17, 2015; 81 FR 57268, Aug. 22, 2016]

§ 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

(a) *Long-term care hospitals subject to the prospective payment system.* To be eligible to receive payment under the prospective payment system specified in this subpart, a long-term care hospital must meet the criteria to be classified as a long-term care hospital set forth in § 412.23(e) for exclusion from the acute care hospital inpatient pro-

spective payment systems specified in § 412.1(a)(1). This condition is subject to the special payment provisions of § 412.22(c), the provisions on change in hospital status of § 412.22(d), the provisions related to hospitals-within-hospitals under § 412.22(e), and the provisions related to satellite facilities under § 412.22(h).

(b) *General requirements.* (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(3) and (h)(6), if applicable, and § 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a long-term care hospital fails to comply fully with these conditions for payment with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may withhold (in full or in part) or reduce Medicare payment to the hospital.

[67 FR 56049, Aug. 30, 2002, as amended at 71 FR 48140, Aug. 19, 2006]

§ 412.507 Limitation on charges to beneficiaries.

(a) *Prohibited charges.* Except as provided in paragraph (b) of this section, a long-term care hospital may not charge a beneficiary for any covered services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system.

(1) If Medicare has paid at the full LTCH prospective payment system standard Federal payment rate, that payment applies to the hospital's costs for services furnished until the high-cost outlier threshold is met.

(2) If Medicare pays less than the full LTCH prospective payment system standard Federal payment rate and payment was not made at the site neutral payment rate (including, when applicable, the blended payment rate), that payment only applies to the hospital's costs for those costs or days used to calculate the Medicare payment.

(3) For cost reporting periods beginning on or after October 1, 2016, for Medicare payments to a long-term care hospital described in § 412.23(e)(2)(ii), that payment only applies to the hospital's costs for those costs or days used to calculate the Medicare payment.

(4) If Medicare has paid at the full site neutral payment rate, that payment applies to the hospital's costs for services furnished until the high-cost outlier is met.

(b) *Permitted charges.* (1) A long-term care hospital that receives a payment at the full LTCH prospective payment system standard Federal payment rate or the site neutral payment rate may only charge the Medicare beneficiary for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter, and for items and services as specified under § 489.20(a) of this chapter.

(2) A long-term care hospital that receives a payment at less than the full LTCH prospective payment system standard Federal payment rate for a short-stay outlier case, in accordance with § 412.529 (which would not include any discharge paid at the site neutral payment rate), may only charge the Medicare beneficiary for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter, for items and services as specified under § 489.20(a) of this chapter, and for services provided during the stay that were not the basis for the short-stay adjusted payment.

(3) For cost reporting periods beginning on or after October 1, 2016, a long-term care hospital described in § 412.23(e)(2)(ii) may only charge the Medicare beneficiary for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter, for items and services as specified under § 489.20(a) of this chapter, and for services provided during the stay for which benefit days were not available and that were not the basis for adjusted LTCH prospective payment system payment amount under § 412.526.

[80 FR 49767, Aug. 17, 2015, as amended at 81 FR 57268, Aug. 22, 2016]

§ 412.508 Medical review requirements.

(a) *Admission and quality review.* A long-term care hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(1) The medical necessity, reasonableness, and appropriateness of hospital admissions and discharges.

(2) The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.523(d)(1) and 412.525(a).

(3) The validity of the hospital's diagnostic and procedural information.

(4) The completeness, adequacy, and quality of the services furnished in the hospital.

(5) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

(b) *Physician acknowledgement.* Payment under the long-term care hospital prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record. The hospital must assure that physicians complete an acknowledgement statement to this effect in accordance with paragraphs (b)(1) and (b)(2) of this section.

(1) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

NOTICE TO PHYSICIANS: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(2) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time

that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(c) *Denial of payment as a result of admissions and quality review.* (1) If CMS determines, on the basis of information supplied by a QIO, that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission or unnecessary multiple admissions of an individual entitled to benefits under Part A, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may, as appropriate—

- (i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or
- (ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (c)(1) of this section, and liability is not waived in accordance with §§ 411.400 through 411.402 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(3) A determination under paragraph (c)(1) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system, is referred to the Department's Office of Inspector General for handling in accordance with § 1001.201 of this title.

[67 FR 56049, Aug. 30, 2002, as amended at 71 FR 48140, Aug. 19, 2006]

§ 412.509 Furnishing of inpatient hospital services directly or under arrangement.

(a) Subject to the provisions of § 412.521(b), the applicable payments made under this subpart are payment

in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following:

(1) Physicians' services that meet the requirements of § 415.102(a) of this subchapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this subchapter.

(b) Medicare does not pay any provider or supplier other than the long-term care hospital for services furnished to a Medicare beneficiary who is an inpatient of the hospital except for services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The long-term care hospital must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements (as defined in § 409.3 of this subchapter).

§ 412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the requirement of §§ 412.22(e)(3) and 412.22(h)(6) to report co-located status, if applicable, and the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

[71 FR 48140, Aug. 18, 2006]

§ 412.513 Patient classification system.

(a) *Classification methodology.* CMS classifies specific inpatient hospital discharges from long-term care hospitals by long-term care diagnosis-related groups (LTC-DRGs) to ensure that each hospital discharge is appropriately assigned based on essential data abstracted from the inpatient bill for that discharge.

(b) *Assignment of discharges to LTC-DRGs.* (1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and the patient's discharge status.

(2) Each discharge from a long-term care hospital is assigned to only one LTC-DRG (related, except as provided in paragraph (b)(3) of this section, to the patient's principal diagnosis), regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. The LTC-DRG classification system provides a LTC-DRG, and an appropriate weighting factor, for those cases for which none of the surgical procedures performed are related to the principal diagnosis.

(c) *Review of LTC-DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a LTC-DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews that hospital's request and any additional information and decides whether a change in the LTC-DRG assignment is appropriate. If the intermediary decides that a different LTC-DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 476.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (c)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

§ 412.515 LTC-DRG weighting factors.

(a) For each LTC-DRG, CMS assigns an appropriate weight that reflects the estimated relative cost of hospital resources used within that group compared to discharges classified within other groups.

(b)(1) Beginning FY 2023, each LTC-DRG weight is subject to a maximum 10 percent reduction as compared to the weight for the same LTC-DRG for the prior fiscal year, except as provided in paragraph (b)(2) of this section.

(2) The limitation described in paragraph (b)(1) of this section does not apply to LTC-DRGs with less than 25 applicable LTCH cases in the data used to determine the relative weights for the fiscal year.

[87 FR 49405, Aug. 10, 2022]

§ 412.517 Revision of LTC-DRG group classifications and weighting factors.

(a) CMS adjusts the classifications and weighting factors annually to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of hospital resources.

(b) Beginning in FY 2008, the annual changes to the LTC-DRG classifications and recalibration of the weighting factors described in paragraph (a) of this section are made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected.

(c) Beginning in FY 2016, the annual recalibration of the weighting factors described in paragraph (a) of this section is determined using long-term care hospital discharges described in § 412.522(a)(2) (or that would have been described in such section had the application of the site neutral payment rate been in effect at the time of the discharge).

[67 FR 56049, Aug. 30, 2002, as amended at 72 FR 26991, May 11, 2007; 80 FR 49768, Aug. 17, 2015]

§ 412.521 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) Except as provided for in § 412.526, the amount of payment under the prospective payment system is based on

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either the long-term care hospital prospective payment system standard Federal payment rate established in accordance with § 412.523, including adjustments described in § 412.525, or the site neutral payment rate established in accordance with § 412.522(c), or, if applicable during a transition period, the blend of the LTCH PPS standard Federal payment rate and the applicable site neutral payment rate described in § 412.522(c)(3).

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance described in subpart G of part 409 of this subchapter) for covered inpatient operating costs as described in §§ 412.2(c)(1) through (c)(4) of this part and § 412.540 and capital-related costs described in subpart G of part 413 of this subchapter associated with furnishing Medicare covered services in long-term care hospitals.

(2) In addition to payment based on prospective payment rates, long-term care hospitals may receive payments separate from payments under the prospective payment system for the following:

(i) The costs of approved medical education programs described in §§ 413.75 through 413.83, 413.85, and 413.87 of this subchapter.

(ii) Bad debts of Medicare beneficiaries, as provided in § 413.89 of this subchapter.

(iii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(iv) Anesthesia services furnished by hospital employed nonphysician anesthesiologists or obtained under arrangements, as specified in § 412.113(c)(2).

(v) The costs of photocopying and mailing medical records requested by a QIO, in accordance with § 476.78(c) of this chapter.

(c) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan that is primary to Medicare pays in full or in part, payment is determined in accord-

ance with the guidelines specified in § 412.120(b).

(d) *Effect of change of ownership on payments under the prospective payment system.* When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(1) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments as provided in § 412.525 and payments for hemophilia clotting factor costs as provided in paragraph (b)(2)(iii) of this section, are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Other payments for the direct costs of approved medical education programs, bad debts, anesthesia services furnished by hospital employed nonphysician anesthesiologists, and costs of photocopying and mailing medical records to the QIO as provided for under paragraphs (b)(2)(i), (ii), (iv), and (v) of this section are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

(e) *Special payment provisions for patients in acute care hospitals that change classification status to LTCH status during a patient stay.* (1) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Payment for the entire patient stay (days prior

to and after the designation of LTCH status) will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under this subpart. The requirements of this paragraph (e)(1) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(2) The days of the patient's stay prior to and after the hospital's designation as a LTCH as specified in paragraph (e)(1) of this section are included for purposes of determining the beneficiary's length of stay.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003; 69 FR 49250, Aug. 11, 2004; 70 FR 47487, Aug. 12, 2005; 75 FR 50416, Aug. 16, 2010; 79 FR 50355, Aug. 22, 2014; 80 FR 49768, Aug. 17, 2015]

§412.522 Application of site neutral payment rate.

(a) *General.* For discharges in cost reporting periods beginning on or after October 1, 2015—

(1) Except as provided for in paragraph (b) of this section, all discharges are paid based on the site neutral payment rate as determined under the provisions of paragraph (c) of this section.

(2) Discharges that meet the criteria for exclusion from site neutral payment rate specified in paragraph (b) of this section are paid based on the standard Federal prospective payment rate established under §412.523.

(b) *Criteria for exclusion from the site neutral payment rate—(1) General criteria—(i) Basis and scope.* A discharge that meets the following criteria is excluded from the site neutral payment rate specified under this section.

(A) The discharge from the long-term care hospital does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation based on the LTC-DRG assignment of the discharge under §412.513; and

(B) The admission to the long-term care hospital was immediately preceded by a discharge from a subsection (d) hospital and meets either the intensive care unit criterion specified in paragraph (b)(1)(ii) of this section or the ventilator criterion specified in paragraph (b)(1)(iii) of this section. In

order for an admission to a long-term care hospital to be considered immediately preceded for purposes of this section, the patient discharged from the subsection (d) hospital must be directly admitted to the long-term care hospital.

(ii) *Intensive care unit criterion.* In addition to meeting the requirements of paragraph (b)(1)(i) of this section, the discharge from the subsection (d) hospital that immediately preceded the admission to the long-term care hospital includes at least 3 days in an intensive care unit (as defined in §413.53(d) of this chapter), as evidenced by at least one of the revenue center codes on the claim for the discharge that indicate such services were provided for the requisite number of days during the stay.

(iii) *Ventilator criterion.* In addition to meeting the requirements of paragraph (b)(1)(i) of this section, the discharge from the long-term care hospital is assigned to a LTC-DRG based on the patient's receipt of ventilator services of at least 96 hours, as evidenced by the procedure code on the discharge bill indicating such services were provided during the stay.

(2) *Special criteria—(i) Definitions.* For purposes of this paragraph (b)(2) the following definitions are applicable:

Severe wound means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis or wound with morbid obesity as identified by the applicable code on the claim from the long-term care hospital.

Wound means an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(ii) *Discharges for severe wounds.* A discharge that occurs on or after April 21, 2016 and before January 1, 2017 for a patient that was treated for a severe wound that meets the all of following criteria is excluded from the site neutral payment rate specified under this section:

(A) The severe wound meets the definition specified in paragraph (b)(2)(i) of this section.

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(B) The discharge is from a long term care hospital that is—

(1) Described in § 412.23(e)(2)(i) and meets the criteria of § 412.22(f); and

(2) Located in a rural area (as defined at § 412.503) or reclassified as rural by meeting the requirements set forth in § 412.103.

(3) *Temporary exception for certain severe wound discharges.*—(i) *Definitions.* For purposes of this paragraph (b)(3) the following definitions are applicable:

Severe wound means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, fistula, as identified by the applicable code on the claim from the long-term care hospital.

Wound means an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(ii) *Discharges for severe wounds.* A discharge that occurs in a cost reporting period beginning during fiscal year 2018 for a patient who was treated for a severe wound that meets all of the following criteria is excluded from the site neutral payment rate specified under this section:

(A) The severe wound meets the definition specified in paragraph (b)(3)(i) of this section.

(B) The discharge is from a long-term care hospital that is described in § 412.23(e)(2)(i) and meets the criteria of § 412.22(f); and

(C) The discharge is classified under MS–LTC–DRG 539, 540, 602, or 603.

(4) *Temporary exception for certain spinal cord specialty hospitals.* For discharges in cost reporting periods beginning in fiscal years 2018 and 2019, the site neutral payment rate specified under this section does not apply if such discharge is from a long-term care hospital that meets each of the following requirements:

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

(ii) 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

(iii) 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.

(c) *Site neutral payment rate.*—(1) *General.* Subject to the provisions of paragraph (c)(2) of this section, the site neutral payment rate is the lower of—

(i) The inpatient hospital prospective payment system comparable per diem amount determined under § 412.529(d)(4), including any applicable outlier payments specified in § 412.525(a); or

(ii) 100 percent of the estimated cost of the case determined under the provisions of § 412.529(d)(2). The provisions for cost-to-charge ratios at § 412.529(f)(4)(i) through (iii) apply to the calculation of the estimated cost of the case under this paragraph.

(iii) For discharges occurring in fiscal years 2018 through 2026, the amount in paragraph (c)(1)(i) of this section is reduced by 4.6 percent.

(2) *Adjustments.* CMS adjusts the payment rate determined under paragraph (c)(1) of this section to account for—

(i) Outlier payments, by applying a reduction factor equal to the estimated proportion of outlier payments under § 412.525(a) payable for discharges from a long-term care hospital described in paragraph (a)(1) of this section to total estimated payments under the long-term care hospital prospective payment system to discharges from a long-term care hospital described in paragraph (a)(1) of this section. The adjustment under this paragraph (c)(2)(i) does not include the portion of the blended payment rate described in paragraph (c)(3)(ii) of this section.

(ii) A 3-day or less interruption of a stay and a greater than 3-day interruption of a stay, as provided for in § 412.531. For purposes of the application of the provisions of § 412.531 to discharges from a long-term care hospital described under paragraph (a)(1) of this section, the long-term care hospital prospective payment system standard Federal payment-related terms, such as “LTC–DRG payment,” “full Federal

LTC-DRG prospective payment,” and “Federal prospective payment,” mean the site neutral payment rate calculated under paragraph (c) of this section.

(iii) The special payment provisions for long-term care hospitals-within-hospitals and satellite facilities of long-term care hospitals specified in §412.534.

(iv) The special payment provisions for long-term care hospitals and satellite facilities of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite facility of the long-term care hospital, as provided in §412.536.

(3) *Transition.* For discharges occurring in cost reporting periods beginning on or after October 1, 2015 and on or before September 30, 2019, payment for discharges under paragraph (c)(1) of this section are made using a blended payment rate, which is determined as—

(i) 50 percent of the site neutral payment rate amount for the discharge as determined under paragraph (c)(1) of this section; and

(ii) 50 percent of the standard Federal prospective payment rate amount for the discharge as determined under §412.523.

(d) *Discharge payment percentage.* (1) For purposes of this section, the discharge payment percentage is a ratio, expressed as a percentage, of Medicare discharges that meet the criteria for exclusion from the site neutral payment rate as described under paragraph (a)(2) of this section to total Medicare discharges paid under this subpart during the cost reporting period.

(2) CMS will inform each long-term care hospital of its discharge payment percentage, as determined under paragraph (d)(1) of this section, for each cost reporting period beginning on or after October 1, 2015.

(3) For cost reporting periods beginning on or after October 1, 2019, if a long-term care hospital's discharge payment percentage for the cost reporting period is not at least 50 percent, discharges in all cost reporting periods beginning after the notification described under paragraph (d)(2) of this

section will be paid under the payment adjustment described in paragraph (d)(4) of this section until reinstated under paragraph (d)(5) or (6) of this section.

(4) For cost reporting periods subject to the payment adjustment under paragraph (d)(3) of this section, the payment for all discharges consists of—

(i) An amount equivalent to the hospital inpatient prospective payment system amount as determined under §412.529(d)(4)(i)(A) and (d)(4)(ii) and (iii); and

(ii) If applicable, an additional payment for high cost outlier cases based on the fixed-loss amount established for the hospital inpatient prospective payment system in effect at the time of the LTCH discharge.

(5) For full reinstatement—

(i) When the discharge payment percentage for a cost reporting period is calculated to be at least 50 percent, any payment adjustment described in paragraph (d)(4) of this section will be discontinued for cost reporting periods beginning on or after the notification described under paragraph (d)(2) of this section.

(ii) A long-term care hospital reinstated under paragraph (d)(5)(i) of this section will be subject to the payment adjustment under paragraph (d)(4) of this section if, after being reinstated, it again meets the criteria in paragraph (d)(3) of this section.

(6) For special probationary reinstatement—

(i) A hospital that would be subject to the payment adjustment under paragraph (d)(4) of this section for a cost reporting period will have application of the payment adjustment delayed for that period if, for the period of at least 5 consecutive months of the 6 months immediately preceding the cost reporting period, the discharge payment percentage is calculated to be at least 50 percent.

(ii) For any cost reporting period to which the payment adjustment under paragraph (d)(4) of this section would have applied but for a delay under paragraph (d)(6)(i) of this section, the payment adjustment under paragraph (d)(4) of this section will be applied to

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all discharges in the cost reporting period if the discharge payment percentage for the cost reporting period is not calculated to be at least 50 percent.

[80 FR 49768, Sept. 1, 2015, as amended at 81 FR 23438, Apr. 21, 2016; 81 FR 57269, Aug. 22, 2016; 82 FR 38512, Aug. 14, 2017; 83 FR 41704, Aug. 17, 2018; 84 FR 42614, Aug. 16, 2019]

§ 412.523 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the initial prospective payment rates for inpatient hospital services furnished by long-term care hospitals, CMS uses—

(1) The best Medicare data available; and

(2) A rate of increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient long-term care hospital services.

(b) *Determining the average costs per discharge for FY 2003.* CMS determines the average inpatient operating and capital-related costs per discharge for which payment is made to each inpatient long-term care hospital using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to FY 2003 by a rate of increase factor, described in paragraph (a)(2) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(c) *Determining the Federal prospective payment rates—(1) General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard Federal rate. The standard Federal rate is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(2) of this section to each hospital's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for FY 2003. Based on the updated cost per discharge, CMS estimates the payments that would have been made to each hospital for FY 2003 under Part

413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard Federal rate.* Subject to the provisions of paragraph (c)(4) of this section, the standard Federal rate is computed as follows:

(i) *For FY 2003.* Based on the updated costs per discharge and estimated payments for FY 2003 determined in paragraph (c)(2) of this section, CMS computes a standard Federal rate for FY 2003 that reflects, as appropriate, the adjustments described in paragraph (d) of this section. The FY 2003 standard Federal rate is effective for discharges occurring in cost reporting periods beginning on or after October 1, 2002 through June 30, 2003.

(ii) *For long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006.* The standard Federal rate for long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year, updated by the increase factor described in paragraph (a)(2) of this section, and adjusted, as appropriate, as described in paragraph (d) of this section. For the rate year from July 1, 2003 through June 30, 2004, the updated and adjusted standard Federal rate is offset by a budget neutrality factor to account for updating the FY 2003 standard Federal rate on July 1 rather than October 1.

(iii) *For long-term care hospital prospective payment system rate year beginning July 1, 2006 and ending June 30, 2007.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2006 and ending June 30, 2007 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by zero percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(iv) *For long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008.* (A) The standard Federal rate for long-term care hospital prospective

payment system rate year beginning July 1, 2007 and ending June 30, 2008 is the same as the standard Federal rate for the previous long-term care hospital prospective payment system rate year. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after July 1, 2007 and before April 1, 2008, payments are based on the standard Federal rate in paragraph (c)(3)(iii) of this section updated by 0.71 percent.

(v) *For long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 2.7 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(vi) *For long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010.* (A) The standard Federal rate for long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 1.74 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after October 1, 2009 and before April 1, 2010, payments are based on the standard Federal rate in paragraph (c)(3)(v) of this section updated by 2.0 percent.

(vii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011.* The standard Federal rate for the long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011, is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by -0.49 per-

cent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(viii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2011, and ending September 30, 2012.* The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2011, and ending September 30, 2012, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.8 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(ix) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2012, and ending September 30, 2013.* (A) The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2012, and ending September 30, 2013, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.8 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after October 1, 2012 and before December 29, 2012, payments are based on the standard Federal rate in paragraph (c)(3)(ix)(A) of this section without regard to the adjustment provided for under paragraph (d)(3)(ii) of this section.

(x) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2013, and ending September 30, 2014.* The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2013, and ending September 30, 2014, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.7 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xi) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2014, and ending September 30, 2015.* The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2014, and ending September

30, 2015, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 2.2 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2015, and ending September 30, 2016.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2015, and ending September 30, 2016, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.7 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xiii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2016, and ending September 30, 2017.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2016, and ending September 30, 2017, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.75 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xiv) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2017, and ending September 30, 2018.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2017, and ending September 30, 2018, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.0 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xv) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2018, and ending September 30, 2019.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2018, and ending September 30, 2019, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by

1.35 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xvi) *For long-term care prospective payment system fiscal year beginning October 1, 2019, and ending September 30, 2020.* The long-term care hospital prospective payment system standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2019 and ending September 30, 2020 is the standard Federal payment rate for the previous long-term care prospective payment system fiscal year updated by 2.5 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xvii) *For long-term care prospective payment system fiscal year 2021 and subsequent fiscal years.* The long-term care hospital prospective payment system standard Federal payment rate for a long-term care hospital prospective payment system fiscal year is the standard Federal payment rate for the previous long-term care prospective payment system fiscal year updated by the percentage increase in the market basket index (as determined by CMS) less a multifactor productivity adjustment (as determined by CMS), and further adjusted, as appropriate, as described in paragraph (d) of this section.

(4) *For fiscal year 2014 and subsequent fiscal years—*

(i) In the case of a long-term care hospital that does not submit quality reporting data to CMS in the form and manner and at a time specified by the Secretary, the annual update to the standard Federal rate specified in paragraph (c)(3) of this section is further reduced by 2.0 percentage points.

(ii) Any reduction of the annual update to the standard Federal rate under paragraph (c)(4)(i) of this section will apply only to the fiscal year involved and will not be taken into account in computing the annual update to the standard Federal rate for a subsequent fiscal year.

(5) *Determining the Federal prospective payment rate for each LTC-DRG.* The Federal prospective payment rate for each LTC-DRG is the product of the weighting factors described in § 412.515

and the standard Federal rate described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard Federal rate.* The standard Federal rate described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* CMS adjusts the LTCH PPS standard Federal payment rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under §412.525(a) payable for discharges described in §412.522(a)(2) (notwithstanding the provisions of §412.525(a)(2)(ii) for FY 2018 and subsequent years.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been paid to long-term care hospitals under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart, excluding the effects of section 1886(b)(2)(E) and (b)(3)(J) of the Act.

(3)(i) *General.* The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates no earlier than December 29, 2012, so that the effect of any significant difference between the data used in the original computations of budget neutrality for FY 2003 and more recent data to determine budget neutrality for FY 2003 is not perpetuated in the prospective payment rates for future years.

(ii) *Adjustment to the standard Federal rate.* The standard Federal rate determined in paragraph (c)(3) of this section is permanently adjusted by 3.75 percent to account for the estimated difference between projected aggregate payments in FY 2003 made under the prospective payment system implemented under this subpart and the projected aggregate payments that would have been made in FY 2003 under Part 413 of this chapter without regard to the implementation of the prospective payment system implemented under this subpart, excluding the effects of sections 1886(b)(2)(E) and (b)(3)(J) of the Act. This adjustment is

transitioned over 3 years beginning in FY 2013.

(iii) *Special rule for certain discharges occurring during FY 2013.* The adjustment applied under paragraph (d)(3)(ii) of this section is not applicable when making payments under this subpart for discharges occurring on or after October 1, 2012, and on or before December 28, 2012.

(4) *Changes to the adjustment for area wage levels.* Beginning in FY 2012, CMS adjusts the standard Federal rate by a factor that accounts for the estimated effect of any adjustments or updates to the area wage level adjustment under §412.525(c)(1) on estimated aggregate LTCH PPS payments.

(5) *Adjustment for changes to the short-stay outlier policy.* The standard Federal rate determined under paragraph (c)(3) of this section is permanently adjusted by a one-time factor so that estimated aggregate payments to LTCH PPS standard Federal rate cases in FY 2018 are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the change in the short-stay outlier policy for FY 2018 under §412.529(c)(4).

(6) *Adjustment for the elimination of the limitation on long-term care hospital admissions from referring hospitals.* The standard Federal payment rate determined in paragraph (c)(3) of this section is adjusted as follows:

(i) For discharges occurring on or after October 1, 2018 and before October 1, 2019, by a one-time factor so that estimated aggregate payments to LTCH PPS standard Federal rate cases in FY 2019, and the portion of estimated aggregate payments to site neutral cases that are paid based on the LTCH PPS standard Federal rate in FY 2019, are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the elimination of the limitation on long-term care hospital admissions from referring hospitals. This adjustment only applies to the fiscal year involved and will not be taken into account in computing the standard Federal payment rate for a subsequent fiscal year.

(ii) For discharges occurring on or after October 1, 2019 and before October 1, 2020, by a one-time factor so that estimated aggregate payments to LTCH

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PPS standard Federal rate cases in FY 2020, and the portion of estimated aggregate payments to site neutral payment rate cases that are paid based on the LTCH PPS standard Federal rate in FY 2020, are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the elimination of the limitation on long-term care hospital admissions from referring hospitals. This adjustment only applies to the fiscal year involved and will not be taken into account in computing the standard Federal payment rate for a subsequent fiscal year.

(iii) For discharges occurring on or after October 1, 2020, by a permanent, one-time factor so that estimated aggregate payments to LTCH PPS standard Federal rate cases in FY 2021 are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the elimination of the limitation on long-term care hospital admissions from referring hospitals.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, a long-term care hospital's Federal prospective payment is computed on the basis of the Federal prospective payment rate multiplied by the relative weight of the LTC-DRG assigned for that discharge. A hospital's Federal prospective payment rate will be adjusted, as appropriate, to account for outliers and other factors as specified in § 412.525.

[67 FR 56049, Aug. 30, 2002]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.523, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.*

(1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the applicable long-term care hospital prospective payment system payment plus an applicable fixed-loss amount. For each long-term care hospital prospective payment system payment year, CMS annually establishes a fixed-loss amount that is the maximum loss

that a long-term care hospital would incur under the long-term care hospital prospective payment system for a case with unusually high costs before receiving an additional payment.

(2)(i) The fixed loss-amount for discharges from a long-term care hospital described under § 412.522(a)(2) is determined for the long-term care hospital prospective payment system payment year, using the LTC-DRG relative weights that are in effect at the start of the applicable long-term care hospital prospective payment system payment year.

(ii) For FY 2018 and subsequent years, the fixed-loss amount for long-term care hospital discharges described under § 412.522(a)(2) 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.

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the applicable long-term care hospital prospective payment system payment and the applicable fixed-loss amount.

(4)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(1) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(2) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean cost-to-charge ratio. CMS establishes and publishes this mean annually.

(3) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

(5) For purposes of this paragraph (a)—

(i) *Applicable long-term care hospital prospective payment system payment means—*

(A) The site neutral payment rate established under § 412.522(c) for long-term care hospital discharges described under § 412.522(a)(1);

(B) The standard Federal prospective payment rates established under § 412.523 for long-term care hospital discharges described under § 412.522(a)(2); or

(C) The standard Federal prospective payment rates established under § 412.523 for discharges occurring on or after October 1, 2015, in a long-term care hospital cost reporting period that begins before October 1, 2015.

(ii) *Applicable fixed-loss amount means—*

(A) For long-term care hospital discharges described under § 412.522(a)(1), the fixed-loss amount established for such cases as provided at § 412.522(c)(2)(i);

(B) For long-term care hospital discharges described under § 412.522(a)(2), the fixed-loss amount established for such cases as provided at § 412.523(e); or

(C) For discharges occurring on or after October 1, 2015 in a long-term care hospital cost reporting period that begins before October 1, 2015, the fixed-loss amount payable to discharges described under § 412.522(a)(2) as set forth in paragraph (a)(5)(ii)(B) of this section.

(b) *Adjustments for Alaska and Hawaii.* CMS adjusts the Federal prospective payment for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(c) *Adjustments for area wage levels.* (1) The labor portion of a long-term care hospital's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS), which reflects the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined in accordance with the definitions set forth in § 412.503) of the hospital compared to the national average level of hospital wages and wage-related costs.

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(i)(A) The appropriate wage index that is established by CMS is updated annually.

(B) Beginning in fiscal year 2023, if CMS determines that an LTCH's wage index value for a fiscal year would decrease by more than 5 percent as compared to the LTCH's wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(ii) The labor portion of a long-term care hospital's Federal prospective payment is established by CMS and is updated annually.

(2) Beginning in FY 2012, any adjustments or updates to the area wage level adjustment under this paragraph (c) will be made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected.

(d) *Special payment provisions.* CMS adjusts the Federal prospective payment to account for—

(1) Short-stay outliers, as provided for in § 412.529.

(2) A 3-day or less interruption of a stay and a greater than 3-day interruption of a stay, as provided for in § 412.531.

(3) [Reserved]

(4) Long-term care hospitals-within-hospitals and satellites of long-term care hospitals as provided in § 412.534.

(5) Long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital, as provided in § 412.536.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34163, June 6, 2003; 68 FR 34515, June 9, 2003; 69 FR 25721, May 7, 2004; 70 FR 24222, May 6, 2005; 71 FR 48140, Aug. 18, 2006; 73 FR 26839, May 9, 2008; 74 FR 43998, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 76 FR 51783, Aug. 18, 2011; 79 FR 50356, Aug. 22, 2014; 80 FR 49769, Aug. 17, 2015; 81 FR 57269, Aug. 22, 2016; 82 FR 38513, Aug. 14, 2017; 83 FR 41705, Aug. 17, 2018; 87 FR 49405, Aug. 10, 2022]

§ 412.526 Payment provisions for a “subclause (II)” long-term care hospital.

(a) *Definition.* A “subclause (II)” long-term care hospital is a hospital that qualifies as an LTCH under section 1886(d)(1)(B)(iv)(II) of the Act.

(b) *Method of payment.* (1) For cost reporting periods beginning on or after October 1, 2003 and before September 30, 2014, payment to a “subclause (II)” long-term care hospital is made under the prospective payment system specified in § 412.1(a)(4) and Subpart O of this part.

(2) For cost reporting periods beginning on or after October 1, 2014, payment to a “subclause (II)” long-term care hospital is made under the prospective payment system specified in § 412.1(a)(4) and under Subpart O of this part, as adjusted. The adjusted payment amount is determined based on reasonable cost, as described at § 412.526(c).

(c) *Determining the adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based reimbursement rules.* Medicare inpatient operating costs are paid based on reasonable cost, subject to a ceiling. The ceiling is the aggregate upper limit on the amount of a hospital's net Medicare inpatient operating costs that the program will recognize for payment purposes, as determined under paragraph (c)(1) of this section.

(1) *Ceiling.* For each cost reporting period, the ceiling is determined by multiplying the updated target amount, as defined in paragraph (c)(2) of this section, for that period by the number of Medicare discharges paid under this subpart during that period.

(2) *Target amounts.* (i) For cost reporting periods beginning during Federal fiscal year 2015, the target amount equals the hospital's target amount determined under § 413.40(c)(4) for its cost reporting period beginning during Federal fiscal year 2000, updated by the applicable annual rate-of-increase percentages specified in § 413.40(c)(3) to the subject period.

(ii) For subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period updated by the applicable annual rate-of-increase percentage specified in § 413.40(c)(3) for the subject cost reporting period.

(3) *Payment for inpatient operating costs.* For cost reporting periods subject to this section, the hospital's Medicare allowable net inpatient operating costs

for that period (as defined at §413.40(a)(3)) are paid on a reasonable cost basis, subject to that hospital's ceiling (as determined under paragraph (c)(1) of this section) for that period.

(4) *Payment for inpatient capital-related costs.* Medicare allowable net inpatient capital costs are paid on a reasonable cost basis, in accordance with the regulations under Part 413 of this chapter.

(5) *Adjustments for extraordinary circumstances—(i) General rules.* (A) CMS may adjust the ceiling determined under paragraph (c)(1) of this section for one or more cost reporting periods when unusual inpatient operating costs have resulted in the hospital exceeding its ceiling imposed under this section due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.

(B) When the hospital requests an adjustment, CMS makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately, identified by the hospital, and verified by the Medicare administrative contractor.

(ii) *Process for adjustment requests.* The provisions of §§413.40(e)(1) through (e)(5) of this subchapter are applicable to extraordinary circumstances adjustment requests under this section.

[79 FR 50356, Aug. 22, 2014]

§412.529 Special payment provision for short-stay outliers.

(a) *Short-stay outlier defined.* “Short-stay outlier” means a discharge with a covered length of stay in a long-term care hospital that is up to and including five-sixths of the geometric average length of stay for each LTC-DRG.

(b) *Adjustment to payment.* CMS adjusts the hospital's Federal prospective payment to account for any case that is determined to be a short-stay outlier, as defined in paragraph (a) of this section, under the methodology specified in paragraph (c) of this section.

(c) *Method for determining the payment amount—(1) Discharges occurring before July 1, 2006.* For discharges from long-

term care hospitals described under §412.23(e)(2)(i), occurring before July 1, 2006, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) One hundred and twenty (120) percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section.

(ii) One hundred and twenty (120) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(iii) The Federal prospective payment for the LTC-DRG determined under paragraph (d)(3) of this section.

(2) *Discharges occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2012.* For discharges from long-term care hospitals described under §412.23(e)(2)(i) occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2012, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) One hundred and twenty (120) percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section.

(ii) One hundred (100) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(iii) The Federal prospective payment for the LTC-DRG as determined under paragraph (d)(3) of this section.

(iv) An amount payable under subpart O computed as a blend of an amount comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4)(i) of this section and the 120 percent of the LTC-DRG specific per diem payment amount determined under paragraph (d)(1) of this section.

(A) The blend percentage applicable to the 120 percent of the LTC-DRG specific per diem payment amount determined under paragraph (d)(1) of this section is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the

LTC-DRG or 25 days, not to exceed 100 percent.

(B) The blend percentage of the amount determined under paragraph (d)(4)(i) of this section is determined by subtracting the percentage determined in paragraph (A) from 100 percent.

(3) *Discharges occurring on or after July 1, 2007 and before December 29, 2007 and discharges occurring on or after December 29, 2012 and on or before September 30, 2017.* For discharges from long-term care hospitals described under § 412.23(e)(2)(i) occurring on or after July 1, 2007, and on or before December 29, 2007 and discharges occurring on or after December 29, 2012, and on or before September 30, 2017, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is adjusted by either of the following:

(i) If the covered length of stay of the case assigned to a particular LTC-DRG is less than or equal to one standard deviation from the geometric ALOS of the same DRG under the inpatient prospective payment system (the IPPS-comparable threshold), the LTCH prospective payment system adjusted payment amount for such a case is the least of the following amounts:

(A) One hundred and twenty (120) percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section.

(B) One hundred (100) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(C) The Federal prospective payment for the LTC-DRG as determined under paragraph (d)(3) of this section.

(D) An amount payable under subpart O of this part comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4) of this section.

(ii) If the covered length of stay of the case assigned to a particular LTC-DRG is greater than one standard deviation from the geometric ALOS of the same DRG under the inpatient prospective payment system (the IPPS-comparable threshold), the LTCH prospective payment system adjusted payment amount for such a case is determined under paragraph (c)(2) of this section.

(4) *Discharges occurring on or after October 1, 2017.* For discharges occurring

on or after October 1, 2017, short-stay outlier payments are determined according to paragraph (c)(2)(iv) of this section.

(d) *Calculation of alternative payment amounts—(1) Determining the LTC-DRG per diem amount.* CMS calculates the LTC-DRG per diem amount for short-stay outliers for each LTC-DRG by dividing the product of the standard Federal payment rate and the LTC-DRG relative weight by the geometric average length of stay of the specific LTC-DRG multiplied by the covered days of the stay.

(2) *Determining the estimated cost of a case.* To determine the estimated cost of a case, CMS multiplies the hospital-specific cost-to-charge ratio by the Medicare allowable charges for the case.

(3) *Determining the Federal prospective payment for the LTC-DRG.* CMS calculates the Federal prospective payment for the LTC-DRG by multiplying the adjusted standard Federal payment rate by the LTC-DRG relative weight.

(4) *Determining the amount comparable to the hospital inpatient prospective payment system per diem amount—(i) General.* Under subpart O, CMS calculates—

(A) An amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge.

(B) An amount comparable to the hospital inpatient prospective payment system per diem amount for each DRG that is determined by dividing the amount that would otherwise be paid under the hospital inpatient prospective payment system computed under paragraph (A) of this section by the hospital inpatient prospective payment system geometric average length of stay of the specific DRG multiplied by the covered days of the stay.

(C) The payment amount specified under paragraph (d)(4)(i)(B) of this section may not exceed the full amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system determined

under paragraph (d)(4)(i)(A) of this section.

(ii) *Hospital inpatient prospective payment system operating standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(A) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors.

(B)(1) Is adjusted for different area wage levels based on the geographic classifications set forth at §412.503 and the applicable hospital inpatient prospective payment system (IPPS) labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals (an LTCH's applicable IPPS wage index).

(2) Beginning in fiscal year 2023, if CMS determines that an LTCH's applicable IPPS wage index value for a fiscal year would decrease by more than 5 percent as compared to the LTCH's applicable IPPS wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(3) For LTCHs located in Alaska and Hawaii, the amount specified in paragraph (d)(4)(ii) of this section is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(iii) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(A) Is adjusted for the applicable inpatient prospective payment system DRG weighting factors.

(B)(1) Is adjusted for the applicable geographic adjustment factors, including local cost variation based on the geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment system (IPPS) wage index value for non-reclassified hospitals (an LTCH's applicable IPPS wage index) and applicable cost of living adjustment factors for LTCHs in Alaska and Hawaii.

(2) Beginning in fiscal year 2023, if CMS determines that an LTCH's appli-

cable IPPS wage index value for a fiscal year would decrease by more than 5 percent as compared to the LTCH's applicable IPPS wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(e) Short-stay outlier payments to long-term care hospitals described under §412.23(e)(2)(ii).

(1) For discharges occurring on or after October 1, 2002, through June 30, 2003, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section;

(ii) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(iii) The Federal prospective payment for the LTC-DRG determined under paragraph (d)(3) of this section.

(2) For discharges occurring on or after July 1, 2003, subject to the provisions of paragraph (e)(2)(v) of this section, the adjusted payment amount for a short-stay outlier is determined under the formulas set forth in paragraphs (e)(1)(i) through (iv) of this section with the following substitutions:

(i) For the first year of the transition period, as specified at §412.533(a)(1), the 120 percent specified for the LTC-DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 195 percent.

(ii) For the second year of the transition period, as specified at §412.533(a)(2), the 120 percent specified for the LTC-DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 193 percent.

(iii) For the third year of the transition period, as specified at §412.533(a)(3), the 120 percent specified for the LTC-DRG specific per diem amount and the 120 percent of the cost

of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 165 percent.

(iv) For the fourth year of the transition period, as specified at § 412.533(a)(4), the 120 percent specified for the LTC-DRG specific per diem amount and 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 136 percent.

(v) For discharges occurring in cost reporting periods beginning on or after October 1, 2006 (beginning with the fifth year of the transition period), as specified at § 412.533(a)(5), short-stay outlier payments are made based on the least of the following amounts:

(A) 120 percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section;

(B) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(C) The Federal prospective payment for the LTC-DRG determined under paragraph (d)(3) of this section.

(f) *Reconciliation of short-stay payments.* Payments for discharges occurring before October 1, 2017 are reconciled in accordance with one of the following:

(1) *Discharges occurring on or after October 1, 2002, and before August 8, 2003.* For discharges occurring on or after October 1, 2002, and before August 8, 2003, no reconciliations are made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(2) *Discharges occurring on or after August 8, 2003, and before October 1, 2006.* For discharges occurring on or after August 8, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(3) *Discharges occurring on or after October 1, 2003, and before October 1, 2006.* For discharges occurring on or after October 1, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(4) *Discharges occurring on or after October 1, 2006.* For discharges occurring on or after October 1, 2006, short-stay outlier payments are subject to the following provisions:

(i) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (f)(4)(ii) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. This request must be approved by the appropriate CMS Regional Office.

(ii) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(iii) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(A) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(B) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. CMS establishes and publishes this mean annually.

(C) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(iv) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(v) At the time of any reconciliation under paragraph (f)(4)(iv) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied

from the midpoint of the cost reporting period to the date of reconciliation.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34163, June 6, 2003; 68 FR 34515, June 9, 2003; 71 FR 27899, May 12, 2006; 71 FR 48141, Aug. 18, 2006; 72 FR 26991, May 11, 2007; 73 FR 24880, May 6, 2008; 73 FR 26839, May 9, 2008; 75 FR 50416, Aug. 16, 2010; 77 FR 53679, Aug. 31, 2012; 82 FR 38513, Aug. 14, 2017; 87 FR 49405, Aug. 10, 2022]

§412.531 Special payment provisions when an interruption of a stay occurs in a long-term care hospital.

(a) *Definitions*—(1) *A 3-day or less interruption of stay defined.* “A 3-day or less interruption of stay” means a stay at a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, IRF, SNF, or the patient's home and readmitted to the same long-term care hospital within 3 days of the discharge from the long-term care hospital. The 3-day or less period begins with the date of discharge from the long-term care hospital and ends not later than midnight of the third day.

(2) *A greater than 3-day interruption of stay defined.* “A greater than 3-day or less interruption of stay” means A stay in a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, an IRF, or a SNF for a period of greater than 3 days but within the applicable fixed-day period specified in paragraphs (a)(2)(i) through (a)(2)(iii) of this section before being readmitted to the same long-term care hospital.

(i) For a discharge to an acute care hospital, the applicable fixed day period is between 4 and 9 consecutive days. The counting of the days begins on the date of discharge from the long-term care hospital and ends on the 9th date after the discharge.

(ii) For a discharge to an IRF, the applicable fixed day period is between 4 and 27 consecutive days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 27th day after discharge.

(iii) For a discharge to a SNF, the applicable fixed day period is between 4 and 45 consecutive days. The counting of the days begins on the day of dis-

charge from the long-term care hospital and ends on the 45th day after the discharge.

(b) *Methods of determining payments.*

(1) For purposes of determining a Federal prospective payment—

(i) *Determining the length of stay.* In determining the length of stay of a patient at a long-term care hospital for payment purposes under this paragraph (b)—

(A) Except as specified in paragraphs (b)(1)(i)(B) and (b)(1)(i)(C) of this section, the number of days that a beneficiary spends away from the long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section is not included in determining the length of stay of the patient at the long-term care hospital when there is no outpatient or inpatient medical treatment or care provided at an acute care hospital or an IRF, or SNF services during the interruption that is considered a covered service delivered to the beneficiary.

(B) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section are counted in determining the length of stay of the patient at the long-term care hospital if the beneficiary receives inpatient or outpatient medical care or treatment provided by an acute care hospital or IRF, or SNF services during the interruption. In the case where these services are provided during some, but not all days of a 3-day or less interruption, Medicare will include all days of the interruption in the long-term care hospitals day-count.

(C) Surgical DRG exception to the 3-day or less interruption of stay policy.

(I) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the beneficiary receives a procedure grouped to a surgical DRG under the hospital inpatient prospective payment system in an acute care hospital during the 2005 and 2006 LTCH prospective payment system rate years are not included in determining the length of stay of the patient at the long-term care hospital.

(2) For discharges occurring on or after July 1 2006, the number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the beneficiary receives a procedure grouped to a surgical DRG under the hospital inpatient prospective payment system in an acute care hospital are included in determining the length of stay of the patient at the long-term care hospital.

(D) The number of days that a beneficiary spends away from a LTCH during a greater than 3-day interruption of stay, as defined in paragraph (a)(2) of this section, is not included in determining the length of stay at the LTCH.

(ii) *Determining how payment is made.* (A) Subject to the provisions of paragraphs (b)(1)(ii)(A)(I) and (b)(1)(ii)(A)(2) of this section, for a 3-day or less interruption of stay under paragraph (a)(1) of this section, the entire stay is paid as a single discharge from the long-term care hospital. CMS makes only one LTC-DRG payment for all portions of a long-term care stay.

(I) For a 3-day or less interruption of stay under paragraph (a)(1) of this section in which a long-term care hospital discharges a patient to an acute care hospital and the patient's treatment during the interruption is grouped into a surgical DRG under the acute care inpatient hospital prospective payment system, for the LTCH 2005 and 2006 rate years, CMS also makes a separate payment to the acute care hospital for the surgical DRG discharge in accordance with paragraph (b)(1)(i)(C) of this section.

(2) For discharges occurring on or after July 1, 2006, for a 3-day or less interruption of stay under paragraph (a)(1) of this section in which a long-term care hospital discharges a patient to an acute care hospital and the patient's treatment during the interruption is grouped into a surgical DRG under the acute care hospital inpatient prospective payment system, the services must be provided under arrangements in accordance with § 412.509(c). CMS does not make a separate payment to the acute care hospital for the surgical treatment. The LTC-DRG payment made to the long-term care hos-

pital is considered payment in full as specified in § 412.521(b).

(3) For a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the patient receives inpatient or outpatient treatment or services at an acute care hospital or IRF, or SNF services, that are not otherwise excluded under § 412.509(a), the services must be provided under arrangements in accordance with § 412.509(c). CMS does not make a separate payment to the acute care hospital, IRF, or SNF for these services. The LTC-DRG payment made to the long-term care hospital is considered payment in full as specified in § 412.521(b).

(B) For a greater than 3-day interruption of stay under paragraph (a)(2) of this section, CMS will make only one LTC-DRG payment for all portions of a long-term care stay. CMS also separately pays the acute care hospital, the IRF, or the SNF in accordance with their respective payment systems, as specified in paragraph (c) of this section.

(iii) *Basis for the prospective payment.* Payment to the long-term care hospital is based on the patient's LTC-DRG that is determined in accordance with § 412.513(b).

(2) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following a 3-day or less interruption of stay under paragraphs (b)(1)(i)(A), (B), or (C) of this section or a greater than 3-day interruption of stay under paragraph (b)(1)(i)(D) of this section is up to and including five-sixths of the geometric average length of stay of the LTC-DRG, CMS will make a Federal prospective payment for a short-stay outlier in accordance with § 412.529(c).

(3) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following a 3-day or less interruption of stay under paragraphs (b)(1)(i)(A), (B), or (C) of this section or a greater than 3-day interruption of stay under paragraph (b)(1)(i)(D) of this section exceeds five-sixths of the geometric average length of stay for the LTC-DRG, CMS will

make one full Federal LTC-DRG prospective payment for the case. An additional payment will be made if the patient's stay qualifies as a high-cost outlier, as set forth in § 412.525(a).

(4) Notwithstanding the provisions of paragraph (a) of this section, if a patient who has been discharged from a long-term care hospital to another facility and is readmitted to the long-term care hospital for additional treatment or services in the long-term care hospital following the stay at the other facility, the subsequent admission to the long-term care hospital is considered a new stay, even if the case is determined to fall into the same LTC-DRG, and the long-term care hospital will receive two separate Federal prospective payments if one of the following conditions are met:

(i) The patient has a length of stay in the acute care hospital that exceeds 9 days from the day of discharge from the long-term care hospital;

(ii) The patient has a length of stay in the IRF that exceeds 27 days from the day of discharge from the long-term care hospital; or

(iii) The patient has a length of stay in the SNF that exceeds 45 days from the day of discharge from the long-term care hospital.

(c) *Payments to an acute care hospital, an IRF, or a SNF during an interruption of a stay.* (1) Payment to the acute care hospital for the acute care hospital stay following discharge from the long-term care hospital will be paid in accordance with the acute care hospital inpatient prospective payment systems specified in § 412.1(a)(1).

(2) Payment to an IRF for the IRF stay following a discharge from the long-term care hospital will be paid in accordance with the IRF prospective payment system specified in § 412.624 of subpart P of this part.

(3) Payment to a SNF for the SNF stay following a discharge from the long-term care hospital will be paid in accordance with the SNF prospective payment system specified in subpart J of part 413 of this subchapter.

[67 FR 56049, Aug. 30, 2002, as amended at 69 FR 25721, May 7, 2004; 70 FR 24222, May 6, 2005; 71 FR 27900, May 12, 2006]

§ 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

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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 accepted. If the date specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section falls on a day that the postal service or other delivery sources are not open for business, the long-term care hospital is responsible for allowing sufficient time for the delivery of the notification before the deadline.

(v) If a long-term care hospital's notification is not received by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, payment will be based on the transition period rates specified in paragraphs (a)(1) through (a)(5) of this section.

(d) *Payments to new long-term care hospitals.* A new long-term care hospital, as defined in § 412.23(e)(4), will be paid based on 100 percent of the standard

Federal rate, as described in § 412.523, with no transition payments, as described in § 412.533(a)(1) through (a)(5).

§ 412.534 Special payment provisions for long-term care hospitals-within-hospitals and satellites of long-term care hospitals, effective for discharges occurring in cost reporting periods beginning on or before September 30, 2016.

(a) *Scope.* Except as provided in paragraph (h), the policies set forth in this section apply to discharges occurring in cost reporting periods beginning on or after October 1, 2004 from long-term care hospitals as described in § 412.23(e)(2)(i) meeting the criteria in § 412.22(e)(2), or satellite facilities of long-term care hospitals that meet the criteria in § 412.22(h).

(b) *Patients admitted from hospitals not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite—*

(1) *For cost reporting periods beginning on or after October 1, 2004 and before July 1, 2007.* Payments to the long-term care hospital as described in § 412.23(e)(2)(i) meeting the criteria in § 412.22(e)(2) for patients admitted to the long-term care hospital or to a long-term care hospital satellite facility as described in § 412.23(e)(2)(i) that meets the criteria of § 412.22(h) from another hospital that is not the co-located hospital are made under the rules in this subpart with no adjustment under this section.

(2) *For cost reporting periods beginning on or after July 1, 2007.* For cost reporting periods beginning on or after July 1, 2007, payments to one of the following long-term care hospitals or long-term care hospital satellites are subject to the provisions of § 412.536 of this subpart:

(i) A long-term care hospital as described in § 412.23(e)(2)(i) of this part that meets the criteria of § 412.22(e) of this part.

(ii) Except as provided in paragraph (h) of this section, a long-term care hospital as described in § 412.23(e)(2)(i) of this part that meets the criteria of § 412.22(f) of this part.

(iii) A long-term care hospital satellite facility as described in § 412.23(e)(2)(i) of this part that meets

the criteria in §412.22(h) or §412.22(h)(3)(i) of this part.

(c) *Patients admitted from the hospital located in the same building or on the same campus as the long-term care hospital or satellite facility.* Except for a long-term care hospital or a long-term care hospital satellite facility that meets the requirements of paragraphs (d) or (e) of this section, payments to the long-term care hospital for patients admitted to it or to its long-term care hospital satellite facility from the co-located hospital are made under either of the following:

(1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2016.* (i) Except as provided in paragraphs (c)(3), (g), and (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007, and for cost reporting periods beginning on or after October 1, 2016 in which the long-term care hospital or its satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the hospital or its satellite facility from the co-located hospital, payments are made under the rules at §§412.500 through 412.541 with no adjustment under this section.

(ii) Except as provided in paragraph (g) or (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2013 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that would be determined under the rules at §412.1(a). Payments for the re-

mainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(iii) In determining the percentage of patients admitted to the long-term care hospital or its satellite from the co-located hospital under paragraphs (c)(1)(i) and (c)(1)(ii) of this section, patients on whose behalf an outlier payment was made to the co-located hospital are not counted towards the 25 percent threshold.

(2) *For cost reporting periods beginning on or after October 1, 2007 and before October 1, 2016.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (c)(1) of this section.

(ii) Payments for a long-term care hospital or long-term care hospital satellite facility subject to paragraph (g) of this section are determined using the methodology specified in paragraph (c)(1) of this section except that 25 percent is substituted with 50 percent.

(3) For a long-term care hospital satellite facility described in §412.22(h)(3)(i), for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, payments will be determined using the methodology specified in paragraph (c)(1) of this section, except that the applicable percentage threshold for Medicare discharges is 50 percent.

(d) *Special treatment of rural hospitals—*(1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2016.* (i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in §412.503 and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007 and for any cost reporting period beginning on or after October 1, 2016 in which the long-term care hospital or long-term care satellite facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to

the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who were admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that were otherwise payable under § 412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's patients are made under the rules in this subpart at §§ 412.500 through 412.541 with no adjustment under this section.

(ii) In determining the percentage of patients admitted from the co-located hospital under paragraph (d)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the 50 percent threshold.

(2) *For cost reporting periods beginning on or after October 1, 2007, and before October 1, 2016.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (d)(1) of this section.

(ii) Payments for long-term care hospitals and long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (d)(1) of this section except that 50 percent is substituted with 75 percent.

(3) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, payment for a long-term care hospital satellite facility described in § 412.22(h)(3)(i) will be determined using the methodology specified in paragraph (c)(1) of this section, except that the applicable percentage threshold for Medicare discharges is 75 percent.

(e) *Special treatment of urban single or MSA-dominant hospitals—*(1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning*

on or after October 1, 2016. (i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or a long-term care hospital satellite facility that is co-located with the only other hospital in the MSA or with a MSA-dominant hospital as defined in paragraph (e)(1)(iv) of this section, for any cost reporting period beginning on or after October 1, 2004, and before October 1, 2007 and for any cost reporting periods beginning on or after October 1, 2016, in which the long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (e)(1)(ii) of this section were admitted to the hospital from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital to exceed the applicable threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that otherwise would be determined under § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart with no adjustment under this section.

(ii) For purposes of paragraph (e)(1)(i) of this section, the percentage used is the percentage of total Medicare discharges in the Metropolitan Statistical Area in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case is less than 25 percent or more than 50 percent.

(iii) In determining the percentage of patients admitted from the co-located hospital under paragraph (e)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the applicable threshold.

(iv) For purposes of this paragraph, an "MSA-dominant hospital" is a hospital that has discharged more than 25 percent of the total hospital Medicare

discharges in the MSA in which the hospital is located.

(2) *For cost reporting periods beginning on or after October 1, 2007 and before October 1, 2016.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (e)(1) of this section.

(ii) Payments for a long-term care hospital or long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (e)(1) of this section except that the percentage of Medicare discharges that may be admitted from the co-located hospital without being subject to the payment adjustment at paragraph (e)(1) of this section is 75 percent.

(3) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, payments for a long-term care hospital satellite facility described in §412.22(h)(3)(i) will be determined using the methodology specified in paragraph (c)(1) of this section, except that the applicable percentage threshold for Medicare discharges is 75 percent.

(f) *Calculation of rates—*(1) *Calculation of LTCH prospective payment system amount.* CMS calculates an amount payable under subpart O equivalent to an amount that would otherwise be paid under the hospital inpatient prospective payment system based on the sum of the applicable hospital inpatient prospective payment system operating standardized amount and capital Federal rate in effect at the time of the LTCH discharge.

(2) *Operating inpatient prospective payment system standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted for different area wage levels based on the geographic classifications set forth at §412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system

wage index value for non-reclassified hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors;

(iii) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(3) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment system wage index value for non-reclassified hospitals, applicable large urban location and cost of living adjustment factors for LTCHs for Alaska and Hawaii, if applicable;

(iii) Includes, where applicable, capital inpatient prospective payment system adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(4) *High cost outlier.* An additional payment for high cost outlier cases is based on the fixed loss amount established for the hospital inpatient prospective payment system.

(g) *Transition period for long-term care hospitals and satellite facilities paid under this subpart.* Except as specified in paragraph (h)(2), in the case of a long-term care hospital or a satellite facility that is paid under the provisions of this subpart on October 1, 2004 or of a hospital that is paid under the provisions of this subpart and whose qualifying period under §412.23(e) began on or before October 1, 2004, the amount paid is calculated as specified below:

(1) For each discharge during the first cost reporting period beginning on or after October 1, 2004, and before October 1, 2005, the amount paid is the amount payable under this subpart with no adjustment under this section

but the hospital may not exceed the percentage of patients admitted from the host during its FY 2004 cost reporting period.

(2) For each discharge during the cost reporting period beginning on or after October 1, 2005, and before October 1, 2006, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during its FY 2004 cost reporting period or 75 percent.

(3) For each discharge during the cost reporting period beginning on or after October 1, 2006, and before October 1, 2007, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during its FY 2004 cost reporting period or 50 percent.

(4) For each discharge during cost reporting periods beginning on or after October 1, 2007, the percentage that may be admitted from the host with no payment adjustment may not exceed 25 percent or the applicable percentage determined under paragraph (d) or (e) of this section.

(h) *Effective date of policies in this section for certain co-located long-term care hospitals and satellite facilities of long-term care hospitals.* Except as specified in paragraph (h)(4) of this section, the policies set forth in this paragraph (h) apply to Medicare patient discharges that were admitted from a hospital located in the same building or on the same campus as a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f) and a satellite facility of a long-term care hospital as described under § 412.22(h)(3)(i) for discharges occurring in cost reporting periods beginning on or after July 1, 2007.

(1) Except as specified in paragraph (h)(4) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is described under this paragraph (h), the thresholds applied at paragraphs (c), (d), and (e) of this section are not less than the following percentages:

(i) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the lesser of 75 percent of the total number of Medicare dis-

charges that were admitted to the long-term care hospital or long-term care hospital satellite facility from its co-located hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the long-term care hospital or satellite from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(ii) For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the lesser of 50 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or the long-term care hospital satellite facility from its co-located hospital or the percentage of Medicare discharges that had been admitted from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(iii) For cost reporting periods beginning on or after July 1, 2009, 25 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or satellite from its co-located hospital during the cost reporting period.

(2) In determining the percentage of Medicare discharges admitted from the co-located hospital under this paragraph, patients on whose behalf a Medicare high cost outlier payment was made at the co-located referring hospital are not counted toward this threshold.

(3) Except as specified in paragraph (h)(4) of this section, for cost reporting periods beginning on or after July 1, 2007, payments to long term care hospitals described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(f) and satellite facilities of long-term care hospitals described at § 412.22(h)(3)(i) are subject to the provisions of § 412.536 for discharges of Medicare patients who are admitted from a hospital not located in the same building or on the same campus as the LTCH or LTCH satellite facility.

(4) For a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f), the policies set forth in this paragraph (h) and in

§ 412.536 do not apply for discharges occurring in cost reporting periods beginning on or after July 1, 2007.

(5) For a long-term care hospital or a satellite facility that, as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Act at the off-campus location, the policies set forth in this paragraph (h) and in § 412.536 do not apply for discharges occurring in cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016.

[69 FR 49251, Aug. 11, 2004, as amended at 69 FR 78529, Dec. 30, 2004; 71 FR 27900, May 12, 2006; 72 FR 26992, May 11, 2007; 73 FR 26839, May 9, 2008; 73 FR 29709, May 22, 2008; 74 FR 43998, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 77 FR 53679, Aug. 31, 2012; 77 FR 63752, Oct. 17, 2012; 79 FR 50356, Aug. 22, 2014]

§ 412.535 Publication of the Federal prospective payment rates.

Except as specified in paragraph (b), CMS publishes information pertaining to the long-term care hospital prospective payment system effective for each annual update in the FEDERAL REGISTER.

(a) For the period beginning on or after July 1, 2003 and ending on June 30, 2008, information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of each long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(b) For the period beginning on July 1, 2008 and ending on September 30, 2009, information of the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of the long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(c) For the period beginning on or after October 1, 2009, information on the unadjusted Federal payment rates

and a description of the methodology and data used to calculate the payment rates are published on or before August 1 prior to the start of the Federal fiscal year which begins October 1, unless for good cause it is published after August 1, but before September 1.

(d) Information on the LTC-DRG classification and associated weighting factors is published on or before August 1 prior to the beginning of each Federal fiscal year.

[68 FR 34163, June 6, 2003, as amended at 73 FR 26839, May 9, 2008]

§ 412.536 Special payment provisions for long-term care hospitals and satellites of long-term care hospitals that discharge Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital, effective for discharges occurring on or before September 30, 2016 or in cost reporting periods beginning on or before June 30, 2016.

(a) *Scope.* (1) Except as specified in paragraph (a)(2) of this section, for cost reporting periods beginning on or after July 1, 2007, the policies set forth in this section apply to discharges from the following:

(i) Long-term care hospitals as described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(e).

(ii) Long-term care hospitals as described in § 412.23(e)(2)(i) and that meet the criteria in § 412.22(f).

(iii) [Reserved]

(iv) Long-term care hospitals as described in § 412.23(e)(5).

(2) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, the policies set forth in this section are not applicable to discharges from:

(i) A long-term care hospital described in § 412.23(e)(5) of this part; or

(ii) [Reserved]

(iii) A long-term care hospital or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Act at the off-campus location.

(b) For cost reporting periods beginning on or after July 1, 2007, payments for discharges of Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite facility will be made under either paragraph (b)(1) or paragraph (b)(2) of this section.

(1) Except as provided in paragraphs (c), (d) and subject to paragraph (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or a long-term care hospital satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the long-term care hospital or the satellite facility from any individual hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payments for the Medicare discharges admitted from that hospital are made under the rules at § 412.500 through § 412.541 in this subpart with no adjustment under this section.

(2) Except as provided in paragraph (c) and (d) and subject to paragraph (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the long-term care hospital or satellite facility from any individual hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payment for the Medicare discharges who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from that referring hospital is the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that would be determined under the rules at subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients admitted from that referring hospital are made under the rules in this subpart at §§ 412.500

through 412.541 with no adjustment under this section.

(3) In determining the percentage of Medicare discharges admitted to the long-term care hospital or long-term care hospital satellite facility from any referring hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, under paragraphs (b)(1) and (b)(2) of this section, patients on whose behalf a Medicare high cost outlier payment was made to the referring hospital are not counted towards the 25 percent threshold from that referring hospital.

(c) *Special treatment of rural hospitals.*

(1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is located in a rural area as defined in § 412.503 that has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or long-term care hospital satellite facility from a hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payment for the Medicare discharges who are admitted from that hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for Medicare discharges is determined at the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that is otherwise payable under subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's Medicare discharges admitted from that referring hospital are made under the rules in this subpart at §§ 412.500 through 412.541 with no adjustment under this section.

(2) In determining the percentage of Medicare discharges admitted from the referring hospital under paragraph (c)(1) of this section, patients on whose behalf a Medicare high cost outlier payment was made at the referring hospital are not counted toward the 50 percent threshold.

(d) *Special treatment of urban single or MSA dominant hospitals.* (1) Subject to

paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that admits Medicare patients from the only other hospital in the MSA or from a referring MSA dominant hospital as defined in paragraph (d)(4) of this section, that are not co-located with the long-term care hospital or with the satellite of a long-term care hospital for any cost reporting period beginning on or after July 1, 2007, in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (d)(2) of this section were admitted to the hospital from the single or MSA-dominant referring hospital, payment for the Medicare discharges who are admitted from the referring hospital and who cause the long-term care hospital or long-term care hospital satellite facility to exceed the applicable threshold for Medicare discharges who have been admitted from the referring hospital is the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that otherwise would be determined under subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's Medicare discharges admitted from that referring hospital are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(2) For purposes of paragraph (d)(1) of this section, the percentage threshold is equal to the percentage of total Medicare discharges in the Metropolitan Statistical Area (MSA) in which the hospital is located that are from the referring hospital, but in no case is less than 25 percent or more than 50 percent.

(3) In determining the percentage of patients admitted from the referring hospital under paragraph (d)(1) of this section, patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward the applicable threshold.

(4) For purposes of this paragraph, an "MSA-dominant hospital" is a hospital that has discharged more than 25 per-

cent of the total hospital Medicare discharges in the MSA in which the hospital is located.

(e) *Calculation of adjusted payment—*
(1) *Calculation of adjusted long-term care hospital prospective payment system amount.* CMS calculates an amount payable under subpart O equivalent to an amount that would otherwise be paid under the hospital inpatient prospective payment system at subpart A, §412.1(a). The amount is based on the sum of the applicable hospital inpatient prospective payment system operating standardized amount and capital Federal rate in effect at the time of the long-term care hospital discharge.

(2) *Operating inpatient prospective payment system standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted for different area wage levels based on the geographic classifications defined at §412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for nonreclassified hospitals. For long-term care hospitals located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors;

(iii) Includes, where applicable, adjustments for indirect medical education costs and for the costs of serving a disproportionate share of low-income patients.

(3) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment

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system wage index value for non-reclassified hospitals, applicable large urban location and cost of living adjustment factors for long-term care hospitals for Alaska and Hawaii, if applicable;

(iii) Includes, where applicable, capital inpatient prospective payment system adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(4) *High cost outlier.* An additional payment for high cost outlier cases is based on the applicable fixed loss amount established for the hospital inpatient prospective payment system.

(f) *Transition period for long-term care hospitals and satellites paid under this section.* In the case of a long-term care hospital or satellite of a long-term care hospital that is paid under the provisions of this section, the thresholds applied under paragraphs (b), (c) and (d) of this section will not be less than the percentages specified below:

(1) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the lesser of 75 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the long-term care hospital or satellite of a long-term care hospital from that referring hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(2) For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the lesser of 50 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or to the satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted from that referring hospital during the long-term care hospital's or

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satellite's RY 2005 cost reporting period.

(3) For cost reporting periods beginning on or after July 1, 2009, 25 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or to the satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital to the long-term care hospital during the cost reporting period.

(4) In determining the percentage of Medicare discharges admitted from the referring hospital under this paragraph, patients on whose behalf a Medicare high cost outlier payment was made at the referring hospital are not counted toward this threshold.

[72 FR 26993, May 11, 2007, as amended at 73 FR 26840, May 9, 2008; 73 FR 29711, May 22, 2008; 74 FR 44000, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 77 FR 53680, Aug. 31, 2012; 77 FR 63752, Oct. 17, 2012; 79 FR 50357, Aug. 22, 2014]

§ 412.538 [Reserved]

§ 412.540 Method of payment for preadmission services under the long-term care hospital prospective payment system.

The prospective payment system includes payment for inpatient operating costs of preadmission services that are—

(a) Otherwise payable under Medicare Part B;

(b) Furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the long-term care hospital, or to an entity wholly owned or wholly operated by the long-term care hospital; and

(1) An entity is wholly owned by the long-term care hospital if the long-term care hospital is the sole owner of the entity.

(2) An entity is wholly operated by a long-term care hospital if the long-term care hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the long-term care hospital also has policymaking authority over the entity.

(c) Related to the inpatient stay. A preadmission service is related if—

(1) It is diagnostic (including clinical diagnostic laboratory tests); or

(2) It is nondiagnostic when furnished on the date of the beneficiary's inpatient admission; or

(3) On or after June 25, 2010, it is non-diagnostic when furnished on the calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary's inpatient admission.

(d) Not one of the following—

(1) Ambulance services.

(2) Maintenance renal dialysis services.

[75 FR 50416, Aug. 16, 2010]

§412.541 Method of payment under the long-term care hospital prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, long-term care hospitals receive payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments—*(1) *Criteria for receiving periodic interim payments.* (i) A long-term care hospital receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of §413.64(h) of this subchapter.

(ii) To be approved for PIP, the long-term care hospital must meet the qualifying requirements in §413.64(h)(3) of this subchapter.

(iii) As provided in §413.64(h)(5) of this subchapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of the PIP resulting in an overpayment to the provider.

(2) *Frequency of payment.* (i) For long-term care hospitals approved for PIP and paid solely under Federal prospective payment system rates under §§412.533(a)(5) and 412.533(c), the intermediary estimates the long-term care hospital's Federal prospective payments net after estimated beneficiary deductibles and coinsurance and makes

biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of payment for the year.

(ii) For long-term care hospitals approved for PIP and paid using the blended payment schedule specified in §412.533(a) for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, the intermediary estimates the hospital's portion of the Federal prospective payments net and the hospital's portion of the reasonable cost-based reimbursement payments net, after beneficiary deductibles and coinsurance, in accordance with the blended transition percentages specified in §412.533(a), and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of both portions of payments for the year.

(iii) If the long-term care hospital has payment experience under the long-term care hospital prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year.

(iv) Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this subchapter.

(v) The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the hospital.* Subject to paragraph (b)(1)(iii) of this section, a long-term care hospital receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the long-term care hospital no longer meets the requirements of §413.64(h) of this subchapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for the costs of an approved education program, blood clotting factors, anesthesia services furnished by hospital-employed non-physician anesthetists or obtained

under arrangement, and photocopying and mailing medical records to a QIO, which are costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a long-term care hospital receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Special interim payment for unusually long lengths of stay*—(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment 60 days after a Medicare beneficiary has been admitted to the hospital. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph.

(e) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(f) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to a long-term care

hospital that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the long-term care hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A request by a long-term care hospital for an accelerated payment must be approved by the intermediary and by CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as long-term care hospital bills are processed or by direct payment by the long-term care hospital.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 10988, Mar. 7, 2003; 71 FR 48141, Aug. 18, 2006]

§ 412.560 Requirements under the Long-Term Care Hospital Quality Reporting Program (LTCH QRP).

(a) *Participation in the LTCH QRP.* A long-term-care hospital must begin submitting data on measures specified under sections 1886(m)(5)(D), 1899B(c)(1), and 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, under the LTCH QRP by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter.

(b) *Data submission requirements and payment impact.* (1) Except as provided in paragraph (c) of this section, a long-term care hospital must submit to CMS data on measures specified under sections 1886(m)(5)(D), 1899B(c)(1) and 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act. Such data must be submitted in a form and manner, and at a time, specified by CMS.

(2) A long-term care hospital that does not submit data in accordance

with sections 1886(m)(5)(C) and 1886(m)(5)(F) of the Act with respect to a given fiscal year will have its annual update to the standard Federal rate for discharges for the long-term care hospital during the fiscal year reduced by 2 percentage points.

(3) CMS may remove a quality measure from the LTCH QRP based on one or more of the following factors:

(i) Measure performance among long-term care hospitals is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better patient outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) *Exception and extension request requirements.* Upon request by a long-term care hospital, CMS may grant an exception or extension with respect to the measures data and standardized patient assessment data reporting requirements, for one or more quarters, in the event of certain extraordinary circumstances beyond the control of the long-term care hospital, subject to the following:

(1) A long-term care hospital that wishes to request an exception or extension with respect to measures data and standardized patient assessment data reporting requirements must submit its request to CMS within 90 days of the date that the extraordinary circumstances occurred.

(2) A long-term care hospital must submit its request for an exception or extension to CMS via email. Email is

the only form that may be used to submit to CMS a request for an exception or an extension.

(3) The email request for an exception or extension must contain the following information:

(i) The CCN for the long-term care hospital.

(ii) The business name of the long-term care hospital.

(iii) The business address of the long-term care hospital.

(iv) Contact information for the long-term care hospital's chief executive officer or designated personnel, including the name, telephone number, title, email address, and physical mailing address. (The mailing address may not be a post office box.)

(v) A statement of the reason for the request for the exception or extension.

(vi) Evidence of the impact of the extraordinary circumstances, including, but not limited to, photographs, newspaper articles, and other media.

(vii) The date on which the long-term care hospital will be able to again submit measures data and standardized patient assessment data under the LTCH QRP and a justification for the proposed date.

(4) CMS may grant an exception or extension to a long-term care hospital that has not been requested by the long-term care hospital if CMS determines that—

(i) An extraordinary circumstance affects an entire region or locale; or

(ii) A systemic problem with one of CMS' data collection systems directly affected the ability of the long-term care hospital to submit measures data and standardized patient assessment data.

(d) *Reconsiderations of noncompliance decisions—* (1) *Written letter of non-compliance decision.* Long-term care hospitals that do not meet the requirement in paragraph (b) of this section for a program year will receive a notification of non-compliance sent through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the MAC.

(2) *Request for reconsideration of non-compliance decision.* A long-term care hospital may request a reconsideration

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of CMS' decision of noncompliance no later than 30 calendar days from the date of the written notification of noncompliance. The reconsideration request by the long-term care hospital must be submitted to CMS via email and must contain the following information:

(i) The CCN for the long-term care hospital.

(ii) The business name of the long-term care hospital.

(iii) The business address of the long-term care hospital.

(iv) Contact information for the long-term care hospital's chief executive officer or designated personnel, including each individual's name, title, email address, telephone number, and physical mailing address. (The physical address may not be a post office box.)

(v) CMS's identified reason(s) for the noncompliance decision from the written notification of noncompliance.

(vi) The reason for requesting reconsideration of CMS' noncompliance decision.

(vii) Accompanying documentation that demonstrates compliance of the long-term care hospital with the LTCH QRP requirements. This documentation must be submitted electronically at the same time as the reconsideration request as an attachment to the email.

(3) *CMS decision on reconsideration request.* CMS will notify long-term care hospitals, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the MAC.

(e) *Appeals of reconsideration requests.* A long-term care hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R, of this chapter.

(f) *Data completion thresholds.* (1) Long-term care hospitals must meet or exceed the following data completeness thresholds with respect to a fiscal year:

(i)(A) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the LTCH Continuity

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Assessment Record and Evaluation (CARE) Data Set (LCDS) on at least 80 percent of the assessments LTCHs submit through the CMS designated data submission system for the FY 2014 through the FY 2025 LTCH QRP.

(B) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the LCDS on at least 85 percent of the assessments LTCHs submit through the CMS designated data submission system beginning with the FY 2026 LTCH QRP.

(ii) The threshold set at 100 percent for measures data collected and submitted using the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) for FY 2014 and all subsequent payment updates.

(2) The thresholds in paragraph (f)(1) of this section apply to all data that must be submitted under paragraph (b) of this section.

(3) A long-term care hospital must meet or exceed both thresholds in paragraph (f)(1) of this section to avoid receiving a 2 percentage point reduction to its annual payment update for a given fiscal year, beginning with the FY 2019 LTCH QRP.

[80 FR 49769, Aug. 17, 2015, as amended at 81 FR 57270, Aug. 22, 2016; 82 FR 38513, Aug. 14, 2017; 83 FR 41705, Aug. 17, 2018; 84 FR 42615, Aug. 16, 2019; 88 FR 59334, Aug. 28, 2023]

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

SOURCE: 66 FR 41388, Aug. 7, 2001, unless otherwise noted.

§ 412.600 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as "inpatient rehabilitation facilities").

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology