

(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.