

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.

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§ 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