

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.

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**§ 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.

(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

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.

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**§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