| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 12594** | **Date: April 26, 2024** |
| | **Change Request 13566** |

**Transmittal 12558 issued March 28, 2024, is being rescinded and replaced by Transmittal 12594, dated April 26, 2024, to update example B in Publication 100-04, Chapter 3, Section 20.1.2.5 - Reconciliation.**

**SUBJECT: Outlier Reconciliation and Cost-to-Charge Ratio (CCR) Updates for the Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to add new criteria for determining which hospitals shall have their outlier payments reconciled under the IPPS and LTCH PPS. We also are crosswalking the calculation of the IPPS operating and capital CCR and the LTCH CCR from Form CMS-2552-1996 cost report to the Form 2552-2010 cost report.

**EFFECTIVE DATE: October 1, 2024**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 1, 2024**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 3/20/20.1.2.1/Cost to Charge Ratios |
| R | 3/20/20.1.2.5/Reconciliation |
| R | 3/150/150.24/Determining the Cost-to-Charge Ratio |
| R | 3/150/150.26/Reconciliation |

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding

continued performance requirements.

## IV. ATTACHMENTS:

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 12594 | Date: April 26, 2024 | Change Request: 13566 |
|---|---|---|---|

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**SUBJECT: Outlier Reconciliation and Cost-to-Charge Ratio (CCR) Updates for the Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS**

**EFFECTIVE DATE: October 1, 2024**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 1, 2024**

## I. GENERAL INFORMATION

**A. Background:** The purpose of this Change Request (CR) is to add new criteria for determining which hospitals shall have their cost reports referred to CMS for review and approval of outlier payment reconciliation at cost report settlement.

Under existing regulations at 42 CFR §412.84(i)(4) for the IPPS and 42 CFR 412.525(a) for the LTCH PPS, outlier payments may be reconciled upon cost report settlement to account for differences between the Cost-to-Charge Ratio (CCR) used to pay the claim at its original submission by the provider and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. Per section 20.1.2.5.A. of Chapter 3 of the Medicare Claims Processing Manual, CMS Pub. 100-04, MACs refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of IPPS hospitals at the time of cost report settlement if the actual operating CCR is found to be plus or minus 10 percentage points or more from the CCR used during that time period to make outlier payments, and the sum of operating and capital outlier payments in that cost reporting period exceeds $500,000. Similarly, under the LTCH PPS, per section 150.26.A. of Chapter 3 of the Medicare Claims Processing Manual, CMS Pub. 100-04., MACs refer cost reports to the CMS Central Office for approval of reconciliation of a LTCH's outlier payments at the time of cost report final settlement if the actual CCR is found to be plus or minus 10 percentage points or more from the CCR used during that cost reporting period to make outlier payments, and outlier payments exceed $500,000 in that cost reporting period. Sections 20.1.2.7 and 150.28 of Chapter 3 of the Medicare Claims Processing Manual specify the process Medicare contractors shall follow for hospitals paid under the IPPS and LTCH PPS with regard to outlier reconciliation, including seeking approval of the CMS Central Office to reconcile outlier payments, performing the reconciliation once the MAC receives approval from the CMS Central Office, and recording outlier reconciliation adjustments on the cost report.

In this CR, we are expanding the criteria above effective for IPPS and LTCH PPS hospital cost reporting periods beginning on or after October 1, 2024. Specifically, for cost reports with a begin date on or after October 1, 2024, MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of IPPS hospitals at the time of cost report settlement if the actual operating CCR is found to be plus or minus 20 percent or more from the CCR used during that time period to make outlier payments, and the sum of operating and capital outlier payments in that cost reporting period exceed $500,000. If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 20.1.2.7 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital. Similarly, for cost reports with a begin date on or after October 1, 2024, MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of hospitals paid under the LTCH PPS at the time of cost report settlement if the actual CCR is found to be plus or minus 20 percent or more from

the CCR used during that time period to make outlier payments, and total outlier payments in that cost reporting period exceed $500,000. If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 150.28 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital.

For new hospitals paid under either the IPPS or LTCH PPS, for cost reporting periods with a begin date on or after October 1, 2024, MACs shall refer to the CMS Central Office for approval of reconciliation at the time of cost report settlement any new hospital in its first cost reporting period (regardless of the change to the CCR and no matter the amount of outlier payments during the cost reporting period). If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in sections 20.1.2.7 (for hospitals paid under the IPPS) and 150.28 (for hospitals paid under the LTCH PPS) of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital.

Also, per section 20.1.2.5.A of Chapter 3 of the Medicare Claims Processing Manual, even if a hospital paid under the IPPS does not meet the criteria for reconciliation, subject to approval of the Regional and Central Office, the Medicare contractor has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 20.1.2.7 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital.

**Note: Based on a 12-month cost report with an October 1, 2024 cost report begin date, MACs would receive the first cost report effective with these changes in March of 2026.**

MACs shall continue to refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of IPPS hospitals at the time of cost report settlement if the actual operating CCR is found to be plus or minus 10 percentage points or more from the CCR used during that time period to make outlier payments, and the sum of operating and capital outlier payments in that cost reporting period exceed $500,000. Also, MACs shall continue to refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of hospitals paid under the LTCH PPS at the time of cost report settlement if the actual CCR is found to be plus or minus 10 percentage points or more from the CCR used during that time period to make outlier payments, and total outlier payments in that cost reporting period exceed $500,000.

Also, per section 150.26 of Chapter 3 of the Medicare Claims Processing Manual, even if a LTCH does not meet the criteria for reconciliation, subject to approval of the CMS Regional and Central Office, the Medicare contractor has the discretion to request that a LTCH's outlier payments in a cost reporting period be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 150.28 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital.

The methodology to calculate an IPPS hospital's operating and capital CCRs from the Medicare cost report is specified in section 20.1.2.1.A. of Chapter 3 of CMS Pub. 100-04. The methodology to calculate an LTCH's overall CCR from the Medicare cost report is specified in section 150.24.A. of Chapter 3 of CMS Pub. 100-04. We also are crosswalking the calculation of the IPPS operating and capital CCRs and the LTCH CCR from Form CMS-2552-1996 cost report to the Form 2552-10 cost report.

All other information regarding outlier payments under the IPPS and high cost outlier payments under the LTCH PPS in Chapter 3 of CMS Pub.100-04 remains unchanged.

**B. Policy:** The specific regulations governing payments and cost report settlement for outlier cases under the IPPS are located at 42 CFR 412.80 through 412.86. The specific regulations governing payments and cost report settlement for high cost outlier cases under the LTCH PPS are located at 42 CFR 412.525(a).

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 13566.1 | For cost reports with a begin date on or after October 1, 2024, MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of IPPS hospitals at the time of cost report settlement if the actual operating CCR is found to be plus or minus 20 percent or greater from the CCR used during that time period to make outlier payments, and the sum of operating and capital outlier payments in that cost reporting period exceed $500,000.<br><br>If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 20.1.2.7 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital. | X | | | | | | | | |
| 13566.1.1 | For hospitals paid under the IPPS, for cost reporting periods with a begin date on or after October 1, 2024, MACs shall refer to the CMS Central Office for approval of reconciliation at the time of cost report settlement any new hospital in its first cost reporting period (regardless of the change to the operating CCR and no matter the amount of outlier payments during the cost reporting period).<br><br>If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 20.1.2.7 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital. | X | | | | | | | | |
| 13566.1.2 | MACs shall continue to refer cost reports to the CMS Central Office for approval of reconciliation of the | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | outlier payments of IPPS hospitals at the time of cost report settlement if the actual operating CCR is found to be plus or minus 10 percentage points or greater from the CCR used during that time period to make outlier payments, and the sum of operating and capital outlier payments in that cost reporting period exceed $500,000.<br><br>If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 20.1.2.7 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital. | | | | | | | | | |
| 13566.2 | For cost reports with a begin date on or after October 1, 2024, MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of hospitals paid under the LTCH PPS at the time of cost report settlement if the actual CCR is found to be plus or minus 20 percent or greater from the CCR used during that time period to make outlier payments, and total outlier payments in that cost reporting period exceed $500,000.<br><br>If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 150.28 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital. | X | | | | | | | | |
| 13566.2.1 | For hospitals paid under the LTCH PPS, for cost reporting periods with a begin date on or after October 1, 2024, MACs shall refer to the CMS Central Office for approval of reconciliation at the time of cost report settlement any new hospital in its first cost reporting period (regardless of the change to the CCR and no matter the amount of outlier payments during the cost reporting period).<br><br>If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 150.28 of Chapter 3 of the Medicare Claims | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | Processing Manual and shall reconcile the outlier payments of the hospital. | | | | | | | | | |
| 13566.2.2 | MACs shall continue to refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of hospitals paid under the LTCH PPS at the time of cost report settlement if the actual CCR is found to be plus or minus 10 percentage points or greater from the CCR used during that time period to make outlier payments, and total outlier payments in that cost reporting period exceed $500,000.<br><br>If the MAC receives approval from the CMS Central Office, MACs shall follow the instructions in section 150.28 of Chapter 3 of the Medicare Claims Processing Manual and shall reconcile the outlier payments of the hospital. | X | | | | | | | | |
| 13566.3 | Under the IPPS, for hospitals using FORM CMS-2552-2010, the MACs shall use the following methodology to calculate a hospital's operating and capital CCRs:<br><br>**Inpatient PPS Operating CCR**<br><br>1. Identify total Medicare inpatient operating costs from the Medicare cost report, from Worksheet D-1, Part II, line 53. (If a positive amount is reported on line 42 for nursery costs, subtract this amount on line 42 from the amount on line 53).<br>2. Identify total Medicare inpatient operating charges (the sum of routine and ancillary charges), from Worksheet D-3, column 2, the sum of lines 30 through 35 and line 202.<br>3. Determine the Inpatient PPS operating CCR by dividing the amount in step 1 by the amount in step 2. | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | **Inpatient Capital CCR**<br><br>1. Identify total Medicare inpatient capital cost from Worksheet D Part 1, column 7, sum of lines 30 through 35, plus Medicare inpatient ancillary capital costs Worksheet D Part II, column 5, line 200.<br>2. Identify total Medicare inpatient capital charges (the sum of routine and ancillary charges), from Worksheet D-3, column 2, the sum of lines 30 through 35 and line 202.<br>3. Determine the Inpatient PPS capital CCR by dividing the amount in step 1 by the amount in step 2. | | | | | | | | | |
| 13566.4 | Under the LTCH PPS, the MACs shall use the following methodology to calculate a hospital's overall Medicare cost-to-charge ratio based on FORM CMS 2552-2010:<br><br>1. Identify total Medicare inpatient costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 9, lines 30 through 35 plus Worksheet D, Part IV, col. 11, line 200).<br>2. Identify total Medicare inpatient charges obtained from Worksheet D-3, Column 2, lines 30 through 35 plus line 202 from the cost report (where possible, these charges should be confirmed with the PS&R data).<br>3. Determine the LTCH's overall Medicare CCR by dividing the amount in step 1 by the amount in step 2. | X | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 13566.5 | CR as Provider Education: MACs shall use the content in the CR to develop relevant education material. Provide a link to the entire instruction in the education content. You can also supplement with local information that would help your provider community bill and administer the Medicare Program correctly. | X | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Michael Treitel, 410-786-4552 or michael.treitel@cms.hhs.gov , Tehila Lipschutz, 410-786-1344 or tehila.lipschutz@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

# Medicare Claims Processing Manual

## Chapter 3 - Inpatient Hospital Billing

**Table of Contents**

*(Rev. 12594; Issued:04-26-24)*

## 20.1.2.1 - Cost to Charge Ratios

*(Rev. 12594; Issued:04-26-24; Effective: 10-01-24; Implementation:10-01-24)*

For discharges before August 8, 2003, Medicare contractors used the latest final settled cost report to determine a hospital's cost-to-charge ratios (CCRs). For those hospitals that met the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective for discharges occurring on or after August 8, 2003 Medicare contractors are to use alternative CCRs rather than one based on the latest settled cost report when determining a hospital's CCR (to download PM A-03-058, visit our Web site at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/CMS-Program-Memoranda. *https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03058.pdf*). For all other hospitals, effective October 1, 2003, Medicare contractors are to use CCRs from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs.

### A. - Calculating a Cost-to-Charge Ratio

For IPPS outlier calculations, Medicare's portion of hospital costs is determined by using hospital specific cost-to-charge ratios (CCRs). At the end of the cost reporting period, the hospital prepares and submits a cost report to its Medicare contractor, which includes Medicare allowable costs and charges. The Medicare contractor completes a preliminary review of the as-submitted cost report and issue a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and an NPR is issued.

The Medicare contractor shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period).

*The* following methodology shall be used to calculate a hospital's operating and capital CCRs *for cost reports using Form CMS-2552-2010:*

**Inpatient PPS Operating CCR**

1) Identify total Medicare inpatient operating costs from the Medicare cost report, from Worksheet D-1, Part II, line 53. (If a positive amount is reported on line 42 for nursery costs, subtract this amount on line 42 from the amount on line 53).

2) Identify total Medicare inpatient operating charges (the sum of routine and ancillary charges), from Worksheet *D-3*, column 2, the sum of lines *30* through *35* and line *202*.

3) Determine the Inpatient PPS operating CCR by dividing the amount in step 1 by the amount in step 2.

**Inpatient Capital CCR**

1) Identify total Medicare inpatient capital cost from Worksheet D Part 1, column *7*, sum of lines *30* through *35*, plus Medicare inpatient ancillary capital costs from Worksheet D Part II, column *5*, line *200*.

2) Identify total Medicare inpatient capital charges (the sum of routine and ancillary charges), from Worksheet *D-3*, column 2, the sum of lines *30* through *35* and line *202*.

3) Determine the Inpatient PPS capital CCR by dividing the amount in step 1 by the amount in step 2.

### B. - Use of Alternative Data in Determining CCRs For Hospitals

Effective August 8, 2003, the CMS Central Office may direct Medicare contractors to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall notify the CMS Regional Office and CMS Central Office to

seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs and/or charges. The CMS Regional Office, in conjunction with the CMS Central Office, must approve the Medicare contractor's request before the Medicare contractor may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all IPPS claims processed after the update. Medicare contractors shall send notification to the Central Office via email at outliersIPPS@cms.hhs.gov.

**C. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS**

The Medicare contractor shall continue to update a hospital's operating and capital CCRs (in the Provider Specific File) each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCRs.

Subject to the approval of CMS, a hospital's operating and/or capital CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all hospital claims processed after the update.

**D. - Request for use of a Different CCR by CMS, the Medicare Contractor or the Hospital**

Effective August 8, 2003, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a hospital will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the hospital, the Medicare contractor notifies the CMS regional office and CMS Central Office of any such request. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request by the hospital or Medicare contractor for use of a different CCR. Medicare contractors shall send requests to the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

**E. - Notification to Hospitals Under the IPPS of a Change in the CCR**

The Medicare contractor shall notify a hospital whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to a hospital about a change to their CCR(s).

**F. - Hospital Mergers, Conversions, and Errors with CCRs**

Effective November 7, 2005, for hospitals that merge, Medicare contractors shall continue to use the operating and capital CCRs calculated from the Medicare cost report associated with the surviving provider number. If a new provider number is issued, as explained in §20.1.2.2 below, Medicare contractors may use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR 412.84 (i)(3)(i), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). For non-IPPS hospitals (e.g., long term care, psychiatric, or rehabilitation hospitals) that convert to IPPS status, or IPPS hospitals that maintain their IPPS status but receive a new IPPS provider number the Statewide average CCR may be applied to that hospital. However, as noted in part C above, the Medicare contractor or the hospital may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report before it converted to IPPS status, or received a new provider number. The Medicare contractor must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS Central and Regional Offices.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek further guidance. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Medicare contractors should contact the CMS Regional and Central Office for further instructions. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

**G. - Maintaining a History of CCRs and Other Fields in the Provider Specific File**

When reprocessing *payments* due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio -27 -SSI Ratio -28 -Medicaid Ratio -47 -Capital Cost to Charge Ratio 49 -Capital IME and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the operating or capital CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

## 20.1.2.5 - Reconciliation

***(Rev. 12594; Issued:04-26-24; Effective: 10-01-24; Implementation:10-01-24)***

**A. - General**

Under 42 CFR §412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. This new regulation was implemented in two phases (further explanation on these two phases is provided below). Hospitals that Medicare contractors identified using the criteria in §I.A. of PM A-03-058 (under which Medicare contractors identified hospitals whose charges appeared to have been increasing at an excessive rate) are subject to the reconciliation policies described in this section for discharges occurring on or after August 8, 2003. For all other hospitals, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

*MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of IPPS hospitals at the time of cost report settlement if* they meet the following criteria:

1. The actual operating CCR is found to be plus or minus 10 percentage points *or more* from the CCR used during that time period to make outlier payments, and

2. *The sum of operating and capital* outlier payments in that cost reporting period exceed $500,000.

*In addition to the criteria above, for cost reports with a begin date on or after October 1, 2024, MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of IPPS hospitals at the time of cost report settlement if they meet the following criteria (see Example B below):*

1. *The actual operating CCR is found to be plus or minus 20 percent or more from the CCR used during that time period to make outlier payments, and*

2. *The sum of operating and capital outlier payments in that cost reporting period exceed $500,000.*

*Also, for hospitals paid under the IPPS, for cost reporting periods with a begin date on or after October 1, 2024, MACs shall refer to the CMS Central Office for approval of reconciliation at the time of cost report settlement any new hospital in its first cost reporting period (regardless of the change to the operating CCR and no matter the amount of outlier payments during the cost reporting period).*

To determine if a hospital meets the criteria above *(the 10 percentage points or 20 percent fluctuation in the operating CCR)*, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §20.1.2.7. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

The *criteria* require a 10 percentage point *or 20 percent* fluctuation in the operating CCR only (and not the capital CCR). However, if a hospital meets *either criterion*, claims will be reconciled using the operating and capital CCRs from the final settled cost report. *New hospitals will have their outlier claims reconciled regardless of the change to the CCR and no matter the amount of outlier payments during the cost reporting period.*

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent via email to outliersIPPS@cms.hhs.gov.

Even if a hospital does not meet the criteria for reconciliation, subject to approval of the Regional and Central Office, the Medicare contractor has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the Central Office via email at outliersIPPS@cms.hhs.gov. Upon approval of the CMS Regional and Central Office that a hospital's outlier claims need to be reconciled, Medicare contractors should follow the instructions in §20.1.2.7.

**B. - Reconciling Outlier Payments**

The Medicare contractors shall notify the CMS Regional Office and CMS Central Office of any hospital that meets the criteria for reconciliation. Notification to the CMS Central Office shall be sent via email to outliersIPPS@cms.hhs.gov. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§20.1.2.6 and 20.1.2.7.

**EXAMPLE A:**

Cost Reporting Period: 09/01/*2014*-08/31/*2014*

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively or final settled *2012* cost report)

Final settled operating CCR from 09/01/*2014*-08/31/*2014* cost report: 0.50

Total outlier payout in 09/01/*2014*-08/31/*2014* cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, *the criteria has been met to trigger reconciliation, and therefore, the Medicare contractor shall notify the CMS Regional Office and Central Office. The provider's outlier payments for this cost reporting period will be reconciled using the correct CCR of 0.50.*

*In the event that multiple CCRs are used in a given cost reporting period, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. (See Example B below for instructions on how to weight the CCRs). The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger a referral to CMS for approval of reconciliation.*

**EXAMPLE B:**

*Cost Reporting Period: 01/01/2025-12/31/2025*

*Operating CCR used to pay original claims submitted during cost reporting period:*

- *0.10 from 01/01/2025-03/31/2025 (This CCR could be from the tentatively settled 2023 cost report)*

- *0.08 from 04/01/2025-12/31/2025 (This CCR could be from the tentatively settled 2024 cost report)*

*Final settled operating CCR from 01/01/2025-12/31/2025 cost report: 0.05*

*Total Outlier payout in 01/01/2025-12/31/2025 cost reporting period: $600,000*

*Weighted Average CCR: 0.085*

| ***CCR*** | ***Days*** | ***Weight*** | ***Weighted CCR*** |
|---|---|---|---|
| *0.10* | *90* | *0.247 (90 Days / 365 Days)* | *(a) 0.0247= (0.10 * 0.247)* |
| *0.08* | *275* | *0.753 (275 Days / 365 Days)* | *(b) 0.0602= (0.08 * 0.753)* |
| ***TOTAL*** | ****365*** | | ***(a)+(b) =0.085*** |

**NOTE: Total Days in a year may be 366 if the year is a leap year.*

*The hospital meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed from 0.085 to 0.05 (which is greater than 20 percent) at the time of final settlement, and the provider received an outlier payment greater than $500,000 for the entire cost reporting period.*

## 150.24 - Determining the Cost-to-Charge Ratio

***(Rev. 12594; Issued:04-26-24; Effective: 10-01-24; Implementation:10-01-24)***

For all LTCHs, effective October 1, 2003, Medicare contractors are to use a CCR from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a LTCH's CCR.

**A. - Calculating an overall LTCH Medicare Cost-to-Charge Ratio**

For the LTCH PPS outlier calculations (short stay and high cost), Medicare's portion of hospital costs are determined by using a hospital's overall Medicare cost-to-charge ratio (CCR). At the end of the cost reporting period, the hospital prepares and submits a cost report to its Medicare contractor, which includes Medicare allowable costs and charges. The Medicare contractor completes a preliminary review of the as-submitted cost report and issues a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and a Notice of Program Reimbursement (NPR) is issued.

The Medicare contractor shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period).

Under the LTCH PPS, the following methodology shall be used to calculate a hospital's overall Medicare cost-to-charge ratio *based on FORM CMS 2552-2010*:

1) Identify total Medicare inpatient costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. *9*, lines *30* through *35* plus Worksheet D, Part IV, col. *11*, line *200*)

2) Identify total Medicare inpatient charges obtained from Worksheet D-*3*, Column 2, lines *30* through *35* plus line *202* from the cost report (where possible, these charges should be confirmed with the PS&R data).

3) Determine the LTCH's overall Medicare CCR by dividing the amount in step 1 by the amount in step 2.

**B. - Use of Alternative Data in Determining CCRs For LTCHs**

Effective August 8, 2003, the CMS Central Office may direct Medicare contractors to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall notify the CMS Regional Office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, a CCR may be revised more often if a change in a LTCHs operations occurs which materially affects a LTCH's costs and/or charges. The CMS Regional Office, in conjunction with the CMS Central Office, must approve the Medicare contractor's request before the Medicare contractor may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all LTCH claims processed after the update. Medicare contractors shall send notification to the CMS Central Office via email to outliersIPPS@cms.gov.

**C. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the LTCH PPS**

Medicare contractors shall continue to update a LTCH's CCR (in the Provider Specific File) each time a more recent cost report is settled (either final or tentative). A revised CCR shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

**D. - Request for use of a Different CCR by CMS, the Medicare Contractor or the LTCH**

Effective August 8, 2003, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a LTCH will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The LTCH is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the LTCH, the Medicare contractor notifies the CMS Regional Office and CMS Central Office of any such request. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request by the LTCH or Medicare contractor for use of a different CCR. Medicare contractors shall send requests via email to the CMS Central at outliersIPPS@cms.hhs.gov.

**E. - Notification to Hospitals Under the LTCH PPS of a Change in the CCR**

The Medicare contractor shall notify a LTCH whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to a LTCH about a change to their CCR.

**F. - Mergers, Conversions and Errors with CCRs**

Effective April 1, 2011, for LTCHs that merge, Medicare contractors shall continue to use the CCR from the LTCH with the surviving provider number. If a new provider number is issued, as explained in §150.25 below, Medicare contractors should use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR §§ 412.525(a)(4)(iv)(C)(1) and 412.529(c)(3)(iv)(C)(1), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). However, the policy of §150.24 part B and C can be applied to determine an alternative to the Statewide average CCR.

For newly classified LTCHs, that is those hospitals (e.g., short term acute, psychiatric, or rehabilitation hospitals) that meet the requirements set forth in 42 CFR 412.23(e), or LTCHs that receive a new LTCH provider number, the Statewide average CCR should be used until a CCR can be computed from the LTCH's cost report data, as described in part A of this section. However, as noted in part C above, the Medicare contractor or the LTCH may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report immediately preceding its classification as a LTCH or receiving a new LTCH provider number. The Medicare contractor must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS Central and Regional Offices. **NOTE: A newly classified LTCH must request an alternative CCR and receive approval from the CMS Central Office prior to the effective date of the hospital's classification as a LTCH in order for that alternative CCR to be effective beginning on the date of classification (as a LTCH). If the request and approval for an alternative CCR occurs after the effective date of the LTCH classification, then the use of the alternative CCR will be effective prospectively beginning with the date of the approval of the alternative CCR request.**

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek further guidance. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Medicare contractors shall contact the CMS regional and Central Office for further instructions. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

**G. - Maintaining a History of CCRs and Other Fields in the Provider Specific File**

When reprocessing *payments* due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: 21 -Case Mix Adjusted Cost Per Discharge, 23 -Intern to Bed Ratio, 24 -Bed Size, 25 -Operating Cost to Charge Ratio, 27 -SSI Ratio and 28 -Medicaid Ratio. A separate history outside of the PSF is not necessary. (**NOTE**: PSF elements 23, 24, 27, 28 and 49 are only required for LTCHs effective 7/11/06.). The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

## 150.26 - Reconciliation

***(Rev. 12594; Issued:04-26-24; Effective: 10-01-24; Implementation:10-01-24)***

**A. - General**

For all LTCHs, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

*MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of hospitals paid under the LTCH PPS at the time of cost report settlement* if they meet the following criteria:

1. The actual CCR is found to be plus or minus 10 percentage points *or more* from the CCR used during that cost reporting period to make outlier payments, and

2. Applicable outlier payments exceed $500,000 in that cost reporting period.

*In addition to the criteria above, for cost reports with a begin date on or after October 1, 2024, MACs shall refer cost reports to the CMS Central Office for approval of reconciliation of the outlier payments of hospitals paid under the LTCH PPS at the time of cost report settlement if they meet the following criteria:*

1. *The actual CCR is found to be plus or minus 20 percent or more from the CCR used during that time period to make outlier payments, and*

2. *Total outlier payments in that cost reporting period exceed $500,000.*

*Also, for hospitals paid under the LTCH PPS, for cost reporting periods with a begin date on or after October 1, 2024, MACs shall refer to the CMS Central Office for approval of reconciliation at the time of cost report settlement any new hospital in its first cost reporting period (regardless of the change to the CCR and no matter the amount of outlier payments during the cost reporting period).*

For the purposes of determining whether outlier payments meet the $500,000 threshold, MACs shall combine the following applicable payments depending on the cost reporting period:

a. For cost reporting periods beginning before October 1, 2015, high cost outlier payments made under 42 CFR §412.525 and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SHORT STAY OUTLIER PAYMENTS" on PS&R Report 11S);
b. For cost reporting periods beginning on or after October 1, 2015 and ending before October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)), and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SSO STANDARD PAYMENTS" on PS&R Report 11S);
c. For cost reporting periods beginning on or after October 1, 2015 and ending after October 1, 2017
    i. For discharges before October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)), and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SSO STANDARD PAYMENTS on PS&R Report 11S);
    ii. For discharges after October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)) ("OUTLIER" on PS&R Report 11S); or

d. For cost reporting periods beginning on or after October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)) ("OUTLIER" on PS&R Report 11S).

To determine if a LTCH meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §150.28. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete. The criteria above replaces the criteria published in §III of PM A-03-058.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent via email to outliersIPPS@cms.hhs.gov.

Even if a LTCH does not meet the criteria for reconciliation, subject to approval of the CMS Regional and Central Office, the Medicare contractor has the discretion to request that a LTCH's outlier payments in a cost reporting period be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the CMS Central Office via email to outliersIPPS@cms.hhs.gov. Upon approval of the CMS regional and Central Office that a LTCH's high cost and short stay outlier claims need to be reconciled, Medicare contractors shall follow the instructions in §§150.27 and 150.28.

**B. Reconciling Outlier Payments**

Beginning with the first cost reporting period starting on or after October 1, 2003, all LTCHs are subject to the reconciliation policies set forth in this section. If a LTCH meets the criteria in part A of this section, the Medicare contractor shall follow the instructions below in §150.28. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§150.27 and 150.28. The following examples demonstrate how to apply the criteria for reconciliation:

Example A

Cost Reporting Period: 01/01/2004-12/31/2004

CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively settled 2002 cost report).

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.50.

Total outlier payments (short-stay and high cost outliers combined) in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 (by more than 10 percentage points) at the time of final settlement, and the provider received greater than $500,000 in (short-stay and high cost) outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the Medicare contractor notifies the CMS Regional Office and CMS Central Office. The provider's outlier payments for this cost reporting period will be reconciled using the actual CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, Medicare contractor shall calculate a weighted average of the CCRs in that cost reporting period. (See Example B below for instructions on how to weight the CCRs). The Medicare contractor shall then compare the weighted average CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total (combined short- stay and high cost) outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

Example B

Cost Reporting Period: 01/01/2004-12/31/2004

CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2004-03/31/2004 (This CCR is from the tentatively settled 2001 cost report)
- 0.50 from 04/01/2004-12/31/2004 (This CCR is from the tentatively settled 2002 cost report)

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.35

Total (short-stay and high cost) outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Weighted Average CCR: 0.474, completed as follows:

| CCR | Days | Weight | Weighted CCR |
|---|---|---|---|
| 0.40 | 91 | 0.248 (91 Days / 366 Days) | (a) 0.099= (0.40 * 0.248) |
| 0.50 | 275 | 0.751 (275 Days / 366 Days ) | (b) 0.375= (0.50 * 0.751) |
| **TOTAL** | ***366** | | **(a)+(b) =0.4742** |

***NOTE**: There are 366 days in the year because 2004 was a leap year.

The LTCH meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed (by more than ten percentage points) from 0.474 to 0.35 at the time of final settlement, and the provider received (combined) outlier payments greater than $500,000 for the entire cost reporting period.