CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2060	**Date: October 1, 2010**
	Change Request 7134

NOTE: Transmittal 2057 dated September 17, 2010, is rescinded and replaced by Transmittal 2060, dated October 1, 2010. This Change Request (CR) is to correct and add an ICD9 code associated with the Renal Failure, Chronic Comorbidity category and to revise the Pricer logic to reflect policy for low volume calculations. All other material remains the same.

SUBJECT: Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2011 update to the IPPS, LTCH PPS, and the IPF PPS. Internet Only Manual updates are incorporated within this Recurring Notification. In addition this CR addresses the FY 2011 update to the Medicare Severity Diagnosis Related Groups (MS-DRGs) and ICD-9-CM coding.

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 2010

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	3/20.1.2.4 /Transfers
R	3/40.2.4/ IPPS Transfers Between Hospitals
R	3/150.9.1.1/Short Stay Outliers
R	3/150.9.1.4/Payment Policy for Co-Located Providers

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:

Manual Instruction

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2060	Date: October 1, 2010	Change Request: 7134

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SUBJECT: Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: This Change Request (CR) outlines changes to the Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Prospective Payment System (PPS) for Long Term Care Hospitals (LTCHs) for FY 2011. The policy changes for FY 2011 appeared in the Federal Register on August 16, 2010. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2010, unless otherwise noted.

This CR also addresses the FY 2011 update to the Medicare Severity Diagnosis Related Groups (MS-DRGs) and ICD-9-CM coding. The coding changes require an update to the IPF PPS comorbidity adjustment, effective October 1, 2010. (Note: The IPF PPS rate changes occurred on July 1, 2010. Refer to Transmittal 1981, CR 6986, issued on June 4, 2010 for IPF PPS policy changes.)

B. Policy:

<u>ICD-9-CM Changes</u>

The ICD-9-CM coding changes are effective October 1, 2010. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables and 6a and 6b of the August 16, 2010, Federal Register. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f.

The Grouper Contractor, 3M-HIS, introduced a new MS-DRG Grouper, Version 28.0, software package effective for discharges on or after October 1, 2010. The GROUPER 28.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare Code Editor (MCE) Version 28.0 which is also developed by 3M-HIS, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2010.

GROUPER 28.0 (for discharges occurring on or after October 1, 2010) – The Fiscal Intermediary Standard System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation on or about August 1, 2010.

MCE 28.0 (for discharges occurring on or after October 1, 2010) – The MCE selects the proper internal tables based on discharge date. Medicare contractors should have received the MCE documentation on or about August 1, 2010.

IPPS FY 2011 Update

The FY 2011 IPPS Pricer is released to the FISS for discharges occurring on or after October 1, 2010. It includes all pricing files for FY2006 through FY 2011 to process bills with discharge dates on or after October 1, 2005.

FY 2011 IPPS Rates

Standardized Amount Update Factor	1.0235 1.0035 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.0235 1.0035 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	$23,075.00
Federal Capital Rate	$420.01
Puerto Rico Capital Rate	$197.66
Outlier Offset-Operating National	0.948999
Outlier Offset-Operating Puerto Rico	0.948079
IME Formula (no change for FY11)	$1.35 \times [(1 + \text{resident to bed ratio})^{.405} - 1]$
MDH/SCH Budget Neutrality Factor	0.996731
MDH/SCH Documentation and Coding Adjustment Factor	0.9718

Operating

Rates with FULL Market Basket

	Wage Index > 1 Labor Share	Wage Index ≤ 1 Labor Share
National	$3,552.91	$3,201.75
PR National	$3,552.91	$3,201.75
PR Specific	$1,518.14	$1,515.70

	Wage Index > 1 Non-Labor Share	Wage Index ≤ 1 Non-Labor Share
National	$1,611.20	$1,962.36
PR National	$1,611.20	$1,962.36
PR Specific	$926.53	$928.97

Rates with REDUCED Market Basket

	Wage Index > 1 Labor Share	Wage Index ≤ 1 Labor Share
National	$3,483.49	$3,139.19
PR National	$3,552.91	$3,201.75
PR Specific	$1,518.14	$1,515.70

	Wage Index > 1 Non-Labor Share	Wage Index ≤ 1 Non-Labor Share

National	$1,579.72	$1,924.02
PR National	$1,611.20	$1,962.36
PR Specific	$926.53	$928.97

Postacute Transfer Policy

See Table 5 of the IPPS Final Rule for a listing of all Postacute and Special Postacute MS-DRGs at the following link.

http://www.cms.gov/AcuteInpatientPPS/IPPS2011/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237948&intNumPerPage=10

Acute Care Transfer Policy Changes

The current acute care transfer policy only applies to transfers between acute care hospitals that participate in the Medicare program ("participating acute care hospitals"); it does not currently apply to acute care hospitals that would otherwise be eligible to be paid under the IPPS, but do not have an agreement to participate in the Medicare program ("nonparticipating acute care hospitals"). It also does not currently apply to IPPS acute care hospital transfers to CAHs.

Effective for discharges on or after October 1, 2010, IPPS hospitals that transfer patients to a non-participating hospital or a CAH would be subject to the transfer policy. Note that the systems changes needed to accommodate this change (transfers to CAHs) will occur in April 2011.

New Technology Add-On Payments

The following items are eligible for new-technology add-on payments in FY 2011:

- Total Artificial Heart (TAH-t) – Effective for FY 2009 through FY 2011, the new technology add-on payment for the TAH-t is triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code V70.7 (Examination of participant in clinical trial). The maximum add-on payment is $53,000 per case.

- Spiration IBV – Effective for FY 2010 and FY 2011- Revised for FY 2011-, cases involving the Spiration® IBV® that are eligible for the new technology add-on payment will be identified by
(1) Assignment to MS-DRGs 163, 164 and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49
(2) Assignment to MS-DRGs 199, 200 and 201 with procedure code 33.71 or 33.73 in combination with diagnosis code 512.1.
The maximum add on payment for the Spiration® IBV® is $3,437.50 per case.

- AutoLITT- New for FY 2011- Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with a procedure code of 17.61 in combination with one of the following primary diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, or 191.9. The maximum add-on payment for a case involving the AutoLITT™ is $5,300.

If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 CFR 412.84(h)) exceed the full DRG payment, an additional amount will be paid that is equal to the lesser of 50 percent of the

costs of the new medical service/technology or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

National Rural Floor Budget Neutrality Adjustment Factors

The wage table loaded for the FY 2011 Pricer contains wage index values ALREADY ADJUSTED BY the national rural floor budget neutrality factor of 0.996641. The Statewide rural floor budget neutrality factors in place in FY 2009 and FY 2010 are not effective for FY 2011 per the Affordable Care Act (ACA) which established the rural floor budget neutrality as a national factor for FY 2011 and subsequent years. To confirm the wage index Pricer uses in calculating payments with the wage index printed in the Federal Register, take the wage index from Pricer and compare it to the wage index value shown in Table 4A, 4B or 4C as appropriate.

Provider Specific File (PSF)

The PSF-required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update all applicable fields for IPPS hospitals effective October 1, 2010, or effective with cost reporting periods that begin on or after October 1, 2010, or upon receipt of an as-filed (tentatively) settled cost report.

Note: Tables 8a and 8b of section VI of the addendum to the IPPS final rule contain the FY 2011 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.175 and the capital ceiling is 0.159.

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2011. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2010, can be found in the FY 2011 IPPS/LTCH PPS final rule.

Expiration of Section 508 Reclassifications

Section 508 of the 2003 Medicare Modernization Act and as extended by the Affordable Care Act (ACA) is extended through September 30, 2010. The PSFs shall be adjusted accordingly for hospitals previously designated as a Section 508 hospital.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A - Section 505 shows the IPPS providers that will be receiving a "special" wage index for FY 2011 (i.e., receive an out-commuting adjustment under section 505 of the MMA). For any provider with a Special Wage Index from FY 2010, FIs and A/B MACs shall remove that special wage index by entering zeros in the field unless they receive a new special wage index as listed in this attachment.

Hospital-Specific (HSP) Rate Update for Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs)

For FY 2011, the hospital-specific (HSP) rates for SCHs and MDHs in the PSF will continue to be entered in FY 2007 dollars. As noted above, the HSP rate market basket update for FY 2011 is 1.0235 (or 1.0035 for hospitals that do not submit quality data) and the budget neutrality factor is 0.996731. Beginning in FY 2011, a

documentation and coding adjustment factor of 0.9718 will also be applied to the HSP rates. We note that HSP logic in Pricer has been modified to use the actual outlier payment amount instead of outlier offset amount.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2011

Sections 3125 and 10314 of ACA provide for a temporary change in the low-volume adjustment for FYs 2011 and 2012. Specifically, for FY 2011 and FY 2012, a hospital qualifies as a low-volume hospital if it is more than 15 road miles from the nearest subsection (d) hospital and has fewer than 1,600 Medicare discharges, that is, discharges of individuals entitled to, or enrolled for, benefits under Part A, during the fiscal year. Sections 3125 and 10314 of the ACA also revised the payment adjustment (the applicable percentage increase) for FYs 2011 and 2012. In the FY 2011 IPPS/LTCH PPS final rule, we discussed the temporary changes to low-volume hospitals and to the low-volume payment adjustment for FYs 2011 and 2012 (August 16, 2010, 75 FR 50238 – 50275, 50414). We established at 412.101(c)(2) that the low-volume adjustment for FYs 2011 and 2012 will be determined as follows:

- Low-volume hospitals with 200 or fewer Medicare discharges will receive a low-volume adjustment of an additional 25 percent for each discharge.
- Low-volume hospitals with Medicare discharges of more than 200 and fewer than 1,600 will receive, for each discharge, a low-volume adjustment of an additional percentage calculated using the formula: [(4/14) – (Medicare discharges/5600)].

As CMS established in that same final rule, for FY 2011, the low-volume payment adjustment will be determined using Medicare discharge data for FY 2009 from the March 2010 update of the MedPAR files. CMS also provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2010 update of the FY 2009 MedPAR files. However, this list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criterion, that is, to qualify for the low-volume adjustment, the hospital also must be located more than 15 road miles from any other IPPS hospital. **In order to receive the applicable low-volume percentage add-on payment for FY 2011, a hospital must meet both the discharge and mileage criteria.**

As specified in the IPPS final rule (75 FR 50274), for FY 2011, the hospital should make its request for low-volume hospital status in writing to its FI or MAC and provide documentation that it meets the mileage criterion by September 1, 2010, so that the applicable low-volume percentage add-on can be applied to payments for its discharges occurring on or after October 1, 2010. FIs/MACs will verify that the hospital meets the discharge criteria by using the table of Medicare discharges based on the March 2010 update of the FY 2009 MedPAR files from the FY 2011 IPPS/LTCH PPS final rule (August 16, 2010, 75 FR 50242 - 50274), or the table posted on the CMS Web site at http://www.cms.gov/AcuteInpatientPPS/IPPS2011/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237932&intNumPerPage=10. We note that in order to facilitate the administrative implementation the ACA provision for low-volume hospitals, as specified in the FY 2011 IPPS final rule, the data to be used to determine the number of Medicare discharges for each IPPS hospital is data from the March 2010 update of the FY 2009 MedPAR (75 FR 50241 and 50274). That is, this data set is the only source that CMS and the FIs/MACs will use to determine the number of Medicare discharges for each IPPS hospital for purposes of the low-volume adjustment for FY 2011.

For an IPPS hospital that submits a request for low-volume hospital status for FY 2011 by September 1, 2010, the FI/MAC will determine whether or not the hospital meets the low-volume hospital criteria prior to October 1, 2010. If the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the applicable low-volume adjustment to discharges occurring on or after October 1, 2010, the effective date of the hospital's low-volume status. However, for requests for low-volume hospital status received after September 1,

2010, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the applicable low-volume adjustment prospectively within 30 days of the date of the FI/MAC's determination such that the applicable low-volume payment adjustment will apply to discharges occurring on or after the effective date of the hospital's low-volume status, within Federal FY 2011.

The FI/MAC is to notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as a low-volume hospital and the effective date of the determination for discharges occurring in FY 2011 by October 15, 2010. The notification may be sent via e-mail to Michele.Hudson@cms.hhs.gov and Maria.Navarro@cms.hhs.gov, and should include the hospital's name, provider number, address (street, city, state and zip code), the number of Medicare discharges, the distance to the nearest IPPS hospital (as well as that hospital's address: street, city, state and zip code) by which the hospital qualified for low-volume status, and the effective date of the low-volume hospital determination. For IPPS hospitals qualified as low-volume hospitals after September 1, 2010, FI/MACs shall notify CMS Central Office as above within 15 days of the determination.

In order to implement this policy for FY 2011, the Pricer will include a new table containing the provider number and discharge count determined from the March 2010 update of the FY 2009 MedPAR file. The discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units. The table in Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).

The existing low-volume indicator field on the Provider specific file (position 74 on the PSF – temporary relief indicator) will be updated by the FI/MAC to hold a value of 'Y' if the provider qualifies for a low-volume payment adjustment, for discharges occurring during FY 2011, by meeting **both the discharge and mileage criteria** at 412.101(b)(2)(ii).

The applicable low-volume percentage add-on payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH, IME and outliers. For SCHs and MDHs, the applicable low-volume percentage add-on payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital Quality Initiative

The FIs and A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) for each hospital that meets the criteria for higher payments per MMA Quality standards. Leave blank if they do not meet the criteria. The hospitals that will receive the quality initiative bonus are listed at the following Web site: **www.qualitynet.org**. This Web site is expected to be updated in September 2010. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site, and FIs and A/B MACs shall update the provider file as needed. Hospitals not receiving the 2.0% RHQDAPU annual payment update for FY 2011 are listed in Attachment B - Hospitals Not Receiving Annual Payment Update (APU) - FY 2011 of this CR.

For new hospitals, FIs and A/B MACs shall enter a '1' in the PSF and provide information to the Quality Improvement Organization (QIO) as soon as possible so that the QIO can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

The FIs and A/B MACs shall provide this information monthly to the QIO in the State in which the hospital has opened. It shall include the following:

- State Code
- Provider Name
- Provider ID number
- Medicare Accept Date
- Contact Name (if available)
- Telephone Number

Capital PPS Payment for Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(II)(D)(3) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties (commonly referred to as "counties") adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. Accordingly, hospitals located in these "Lugar counties" (commonly referred to as "Lugar hospitals") are deemed to be located in an urban area and receive the Federal payment amount for the urban area to which they are redesignated. To ensure these "Lugar hospitals" are paid correctly under the capital PPS, FIs and A/B MACs shall enter the urban Core Based Statistical Area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF. (Note: this may be different from the urban CBSA in the wage index CBSA field on the PSF for "Lugar hospitals" that are reclassified for wage index purposes.)

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 for purposes of Capital PPS payments

Hospitals reclassified as rural under §412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see §412.320(a)(1)). The FIs and A/B MACs shall enter the rural CBSA (2-digit State code) in the standardized amount CBSA field on the PSF rather than the urban CBSA corresponding to their actual location to ensure correct payment under the capital PPS. Similarly, the Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under §412.103 is determined from the applicable Statewide rural wage index.

Frontier Wage Index RFBN

Section 10324(a)(1) of ACA amended section 1886(d)(3)(E) of the Act by adding a provision under new subsection (iii) to establish an adjustment to create a wage index floor of 1.00 for all hospitals located in States determined to be "frontier States," beginning in FY 2011.

For the final FY 2011 IPPS wage indices, we identified the following frontier States that will receive the floor adjustment for FY 2011. These frontier States also are identified by a footnote in Table 4D-2 of the Addendum to the final rule. Note: The above is informational. Pricer will calculate all applicable frontier wage indices.

Frontier States Identified for the FY 2011 Wage Index Floor Adjustment Under Section 10324(a) of the ACA

State	Total Counties	Frontier Counties	Percent of Counties Identified As Frontier
Montana	56	45	80%
Wyoming	23	17	74%
North Dakota	53	36	68%
Nevada	17	11	65%
South Dakota	66	34	52%

Section 1109

Section 1109 of Pub. L. 111-152 provides for additional payments for FYs 2011 and 2012 to "qualifying hospitals." Section 1109(d) defines a "qualifying hospital" as a "subsection (d) hospital . . . that is located in a county that ranks, based upon its ranking in age, sex and race adjusted spending for benefits under parts A and B . . . per enrollee within the lowest quartile of such counties in the United States." In the FY 2011 IPPS final rule, we provided tables with a list of qualifying hospitals, their payment weighting factors and eligible counties. As finalized in the FY 2011 IPPS final rule, we expect to distribute $150 million for FY 2011 and $250 million for FY 2012 to qualifying hospitals. We plan on distributing these payments through the individual hospital's Medicare contractor by means of an annual one-time payment during each of FY 2011 and FY 2012. We plan on issuing instructions to Medicare contractors subsequent to this notification on the distribution of these payments. Qualifying hospitals will report these additional payments on their Medicare hospital cost report corresponding to the appropriate cost reporting period for which the hospitals receive the payments. We plan to issue additional cost reporting instructions for qualifying hospitals and Medicare contractors on how to report these additional payments. We are requiring these payments be reported on the cost report for tracking purposes only. These additional payments will not be adjusted or settled by the FI or MAC on the cost report.

LTCH PPS FY 2011 Update

FY 2011 LTCH PPS Rates

Federal Rate	$39,599.95
High Cost Outlier Fixed-Loss Amount	$18,785.00
Labor Share	75.271%
Non-Labor Share	24.729%

MS-LTC-DRG Update

The LTCH PPS Pricer has been updated with the Version 28.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2010, and on or before September 30, 2011.

Provider Specific File (PSF)

The PSF-required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update the all applicable fields for LTCHs effective October 1, 2010, or effective with cost reporting periods that begin on or after October 1, 2010, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8C of section VI of the addendum to the PPS final rule contain the FY 2011 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific total CCR from the latest settled or tentatively settled cost report. The LTCH total CCR ceiling for FY 2011 is 1.231.

Cost of Living Adjustment (COLA) Update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2011. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2010, can be found in the FY 2011 IPPS/LTCH PPS final rule.

Core-Based Statistical Area (CBSA)-based Labor Market Definition Changes
There are several revisions to the Core-Based Statistical Area (CBSA)-based labor market definitions used under the LTCH PPS, which are the basis of the wage index adjustment, effective October 1, 2010. The following changes affect the CBSA codes used for the wage index assignment under the LTCH PPS:

(1) For any LTCHs currently located in CBSA 14600, the CBSA code on the PSF will need to be changed to 35840 (from 14600) effective October 1, 2010, due to a title change for that CBSA.

(2) For any LTCHs currently located in CBSA 23020, the CBSA code on the PSF will need to be changed to 18880 (from 23020) effective October 1, 2010, due to a title change for that CBSA.

(3) For any LTCHs currently located in CBSA 48260, the CBSA code on the PSF will need to be changed to 44600 (from 48260) effective October 1, 2010, due to a title change for that CBSA.

Changes to Certain LTCH PPS Payment Policies made by the ACA of 2010

Section 3106 and 10312 of the ACA provided for an extension of certain payment rules under the LTCH PPS and the moratorium on the establishment of certain LTCHs and LTCH satellites and the increase in number of beds in existing LTCHs and LTCH satellites. The changes required by sections 3106 and 10312 of the ACA are self-implementing and were announced in the FY 2011 IPPS/LTCH PPS final rule and we are revising sections 150.9.1.1 and 150.9.1.4 of Pub. 100-04, Chapter 3 of the Internet Only Manual to reflect these changes as applicable.

IPF PPS Update

DRG Adjustment Update

The IPF PPS has DRG specific adjustments for MS-DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric MS-DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of our identified psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments.

The IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and MS-DRG classification system, in order to maintain consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS. The following table lists the FY 2011 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs for which the IPF PPS provides an adjustment. This table is only a listing of FY 2011 **new** codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the MS-DRGs. When coded as a principal diagnosis, these codes

receive the correlating MS-DRG adjustment. Note that there are no invalid ICD-9-CM diagnosis codes that impact the MS-DRG adjustment under the IPF PPS for FY 2011.

Diagnosis Code	Description	DRG Adjustment
799.51	Attention or concentration deficit	886
799.52	Cognitive communication deficit	884
799.54	Psychomotor deficit	884
799.55	Frontal lobe and executive function deficit	884
799.59	Other signs and symptoms involving cognition	884

The table below lists the FY 2011 **revised** ICD-9-CM diagnosis code that impacts the MS-DRG adjustment under the IPF PPS. The table only lists the FY 2011 **revised** code and does not reflect all of the currently valid ICD codes applicable for the IPF PPS MS-DRG adjustment.

Diagnosis Code	Description	MS-DRG
307.0	Adult onset fluency disorder	887

The table below lists the seventeen MS-DRG adjustment categories for which we are providing an adjustment, their respective codes and their respective adjustment factors. Please note that we do not plan to update the regression analysis until we analyze IPF PPS data. The MS-DRG adjustment factors, shown below, are effective October 1, 2010, and will continue to be paid for RY 2011.

MS-DRG	MS-DRG Description	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnosis of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neurosis	0.99
882	Neurosis except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity Adjustment Update

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes for certain comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category.

The IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

Comorbidities and Complications (CCs) are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and shall not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

The IPF PPS utilizes the MS-Severity DRG coding system in order to maintain consistency with the IPPS, which is effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. We are currently using the FY 2011 GROUPER, Version 28.0 which is effective for discharges occurring on or after October 1, 2010.

The following table lists the FY 2011 **new** ICD-9-CM diagnosis codes which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. The table lists only the FY 2011 new codes, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. The RY 2011 IPF Pricer will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2010. There are no invalid or revised ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS for FY 2011.

Diagnosis Code	Description	Comorbidity Category
237.73	Schwannomatosis	Oncology
237.79	Other neurofibromatosis	Oncology

The table below lists the seventeen comorbidity categories for which we are providing an adjustment, their respective codes, including the new FY 2011 ICD codes, and their respective adjustment factors.

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Developmental Disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheostomy	51900 through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V4511, V4512,V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889,	1.07

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
	and 07950 through 07959	
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial Openings - Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7134.1	FISS shall install and pay claims with the FY 2011 IPPS Pricer for discharges on or after October 1, 2010.						X				
7134.2	FISS shall install and pay claims with the FY 2011 LTCH Pricer for discharges on or after October 1, 2010.						X				
7134.3	FISS shall install and pay claims with the ICD-9 update to the RY 2011 IPF Pricer for discharges on or after October 1, 2010.						X				
7134.4	FISS shall install and edit claims with the MCE version 28.0 and GROUPER version 28.0 software with the implementation of the FY 2011 October quarterly release.						X				
7134.5	FISS shall update the edit(s) originally created in CR 6557.5.2 with the updated list of Section 401 hospitals by referring to Table 9(c) of the IPPS Rule.						X				
7134.6	CWF shall update edit 7272 with the postacute care (PAC) MS-DRGs listed in Table 5 of the IPPS Final Rule (link on page 2 of this CR) effective for discharges on or after 10/01/2010 (includes special pay). NOTE: The MS-DRGs have not changed from FY 2010.									X	
7134.7	Contractors shall inform the QIO of any new hospital that has opened for hospital quality purposes.	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7134.8	Contractors shall update relevant portions of the provider specific file in accordance with this CR.	X		X							
7134.8.1	Contractors shall update the PSF for CBSA and special wage index changes per the policy sections of this CR.	X		X							
7134.8.2	Contractors shall notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as a low-volume hospital and the effective date of the determination for discharges occurring in FY 2011 by October 15, 2010. Contractors shall also notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro of IPPS hospitals qualified as low-volume hospitals after September 1, 2010, within 15 days of the determination.	X		X							
7134.9	Contractors shall be aware of the manual updates included within this CR.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7134.10	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirement:

X-Ref Requirement Number	Recommendations or other supporting information:
7134.5	Per CRs 6557.5.2 and 6557.7, contractors shall only pay for KDE services when billed on a 85X, on a covered TOB received from a rural hospital, or on a covered TOB received from a hospital deemed rural under section 401 (i.e., the provider is found on the annually updated Table 9C of the IPPS Rule)

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

V. CONTACTS

Pre-Implementation Contact(s):
Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov or 410-786-0187
Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986
Cami DiGiacomo at cami.digiacomo@cms.hhs.gov or 410-786-5888

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

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.

Attachment A-Section 505

Attachment B - Hospitals Not Receiving Annual Payment Update (APU) - FY 2011

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

20.1.2.4 - Transfers
(Rev. 2060, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

A. Transfers Between IPPS Hospitals

For transfers between IPPS hospitals, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold for the transferring hospital is equal to the *fixed loss* outlier threshold for non-transfer cases *(adjusted for geographic variations in costs),* divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case plus one day.

The payment to the final discharging hospital is made at the full prospective payment rate. The outlier threshold and payment are calculated the same as any other discharge without a transfer. For further information on transfers between IPPS hospitals, see section 40.2.4, part A of this manual.

B. Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that do not Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is not subject to the postacute care transfer policy, the transferring hospital is paid the full IPPS rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold and payment are calculated the same as any other discharge without a transfer.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that do not fall within a DRG that is subject to the postacute care transfer policy, see section 40.2.4, part B of this manual.

C. Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is subject to the postacute care transfer policy, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. In general, the outlier threshold for the transferring hospital is equal to the *fixed loss* outlier threshold for non-transfer cases *(adjusted for geographic variations in costs),* divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case plus one day. If a discharge is assigned to a special pay DRG subject to the post acute care transfer policy, the outlier threshold is equal to the fixed loss cost outlier threshold for non-transfer cases *(adjusted for geographic variations*

in costs), divided by the geometric mean length of stay for the DRG, multiplied by 0.5 plus the product of the length of stay plus one day multiplied by 0.5.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that fall within a DRG subject to the postacute care transfer policy, see section 40.2.4, part C and D.

40.2.4 – IPPS Transfers Between Hospitals

(*Rev*. 2060, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10*)*

A3-3610.5, HO-415.8

A discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred *from the hospital where the patient was admitted* to another *hospital* for additional treatment once the patient's condition has stabilized or a diagnosis established. The following procedures apply. See §20.2.3 for proper Pricer coding to ensure that these requirements are met.

Note: CMS established Common Working File Edits (CWF) edits in January 2004 to ensure accurate coding and payment for discharges and/or transfers.

A – Transfers Between IPPS Prospective Payment *Acute Care* Hospitals

For discharges occurring on or after October 1, 1983, when a hospital inpatient is discharged to another acute care hospital, as described in 42 CFR 412.4(b), payment to the transferring hospital is based upon a graduated per diem rate (i.e., the prospective payment rate divided by the geometric mean length of stay for the specific MS-DRG into which the case falls; hospitals receive twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount). If *the stay is* less than l day, l day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. However, this day does not count against the patient's Medicare days (utilization days), since this Medicare day is applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital (see §40.1.D). If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate. *Payment is made to the final discharging hospital at the full prospective payment rate.*

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage index values and any other adjustments are those that are appropriate for each hospital. Where a transfer case results in treatment in the second hospital under a *MS*-DRG different than the *MS*-DRG in the transferring hospital, payment to each is based upon the *MS*-DRG under which the patient was treated. For transfers on or after October 1, 1984, the transferring hospital may be paid an outlier payment. *For further information on outlier payments for transfer cases, see section 20.1.2.4 of this manual.*

An exception to *the transfer* policy applies to *MS-DRG 789*. The weighting factor for *this MS-*DRG assume*s* that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into *this MS*-DRG is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

Effective for discharges on or after October 1, 2003, patients who leave against medical advice (LAMA), but are admitted to another inpatient PPS hospital on the same day as they left, will be treated as transfers and the transfer payment policy will apply.

B – Transfers from an IPPS Acute Care Hospital to Hospitals or Hospital Units Excluded from the IPPS

When patients are transferred to hospitals or units excluded from IPPS, the full inpatient prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs or *is made at the rate of its respective payment system* (*s*ee exceptions in paragraph C of this section).

A *transfer* payment is made to the transferring hospital when patients are transferred to a hospital that would ordinarily be paid under prospective payment, but *that* is excluded because of participation in a state or area wide cost control program. Also, a *transfer* payment is made where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS *and certain hospitals that are excluded from IPPS. These include:*

- *An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program (Patient Status Code 02)*

- *A critical access hospital (Patient Status Code 66)*

C – *Postacute Care* Transfers
(Previously Special 10 DRG Rule)

For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying *Postacute MS*-DRGs *referenced* in paragraph *(D*) of this section and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under subpart B of 42 CRF 412). *F*acilities excluded from IPPS are inpatient rehabilitation facilities and units (Patient Status Code 63), long term care hospitals *(Patient Status Code 62),* psychiatric hospitals and units *(Patient Status Code 65)*, children's hospitals, and cancer hospitals *(Patient Status Code 05).*

- To a skilled nursing facility *(Patient Status Code 03).*

- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge *(Patient Status Code 06)*.

Specific transfer cases under this paragraph qualify for payment under an alternative methodology. These include transfer cases in which the patient's discharge is assigned, as described in 42 CFR 412.4(f)(2), (f)(5) and (f)(6), to one of the qualifying Special Pay MS-DRGs referenced in paragraph (D) of this section. For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

D – Qualifying *MS-*DRGs

Refer to Table 5 of the applicable Fiscal Year IPPS Federal Register for the list of qualifying Postacute MS-DRGs and Special Pay Postacute MS-DRGs.

150.9.1.1 - Short-Stay Outliers

(*Rev*. 2060, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10*)*

- Generally, a short-stay outlier (SSO) is a case that has a covered length of stay between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped. Effective for LTCH PPS discharges occurring on or before June 30, 2006, the adjusted payment for an SSO case is the least of:

  - 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio (CCR) and covered charges from the bill);

  - 120 percent of the LTC-DRG specific per diem payment (determined using the LTC-DRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case); or

  - The full LTC-DRG payment.

To compute 120% of cost:

- Charges x CCR = Cost ($13,870.33) x (0.8114) = $11,254.39

- 120% of cost = $11,254.39 x 1.2 = $13,505.27

To compute 120% of the specific LTC-DRG per diem:

- Full LTC-DRG payment / ALOS LTC-DRG x LOS of the case x 1.2

  Full LTC-DRG payment:

$34,956.15 (FY 2003 standard Federal rate)

x 0.72885 (labor %)

$25,477.79 (labor share)

x 1.0301 (1/5th wage index value for FY 2003)

$26,244.67 (wage adjusted labor share)

+ 9,478.36 (non-labor share=$34,956 x 0.27115)

$35,723.03 (adjusted standard Federal rate)

x 1.4103 (LTC-DRG 113 relative weight)

$50,380.19 (full LTC-DRG payment

Per Diem = $50,380.19 / 36.9 (ALOS LTC-DRG 113) = $1365.32 per day

If LOS of case is 10 days, then 120% of per diem = $1365.32 per day x 10 days x 1.2 = $16,383.80.

In this example, the case is paid 120% of cost ($13,505.27) since it is less than $120% of the specific LTC-DRG per diem ($16,383.80) and the full LTC-DRG payment ($50,380.19).

For discharges occurring on or after August 8, 2003, short-stay outlier payments are to be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

For RY 2007, the SSO policy was revised as follows:

- Effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case is equal the least of:
  - 100 percent of estimated cost of the case,
  - 120 percent of the LTC-DRG per diem amount,
  - the full LTC-DRG payment, or

- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

Under the blend alternative, the percentage of the 120 percent LTC-DRG per diem amount is based on the ratio of the (covered) length of stay of the case to the lesser of the SSO threshold for the LTC-DRG (i.e., 5/6ths of the geometric ALOS of the LTC-DRG) or 25 days. As the length of stay reaches the lower of the five-sixths SSO threshold or 25 days, the adjusted SSO payment is no longer be limited by this fourth option. This is because for SSO cases with a LOS of 25 days or more, the amount determined under the blend alternative is equal to 100 percent of the 120 percent of the LTC- DRG specific per diem amount and 0 percent of the IPPS comparable per diem amount. In addition, the LOS in the numerator cannot exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent). The remaining percent of the blend alternative (that is, 100 percent minus the percentage applied to the 120 percent of the LTC-DRG per diem amount) is applied to the IPPS comparable per diem amount (capped at the full IPPS comparable amount).

The following examples illustrate how the blend alternative is calculated when the LTCH patient is grouped to hypothetical DRG XYZ. For purposes of this example, for DRG XYZ, the full LTC DRG payment is $38,597.41, the LTCH PPS geometric ALOS is 33.6 days, the LTCH PPS SSO threshold (i.e., 5/6ths of the geometric ALOS) is 28.0 days, the full IPPS comparable amount is $8,019.82, and the IPPS geometric ALOS is 4.5 days.

SSO Example #1 – LOS equals 11 Days:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$38,597.41 x11 days x 1.2 33.6 days	$15,163.27
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days	11 days ÷ 25 days	0.44
1c	Determine the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the LTC-DRG per diem amount in step (1-a)	0.44 x $15,163.28	$6,671.84
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$8,019.82 x 11 days 4.5 days	$19,604.00

2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($19,604.00)	$8,019.82
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 – 0.44	0.56
2d	Determine the IPPS comparable per diem portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable amount determined in step (2-b)	0.56 x $8,019.82	$4,491.10
3	Compute the blend alternative	Add the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$6,671.84 + $4,491.10	$11,162.94

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

<u>SSO Example #2 – LOS equals 27 Days</u>:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	<u>$38,597.41</u> x 27 days 33.6 days x 1.2	$37,218.93
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days; however, since the LOS in the numerator exceeds the number of days in the denominator, the percentage equals 100 percent	27 days ÷ 25 days is > 1; therefore percent is 1.00	1.00
1c	Determine the 120 percent of the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the 120 percent of the LTC-DRG per diem amount in step (1-a)	1.0 x $37,218.93	$37,218.93

2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$8,019.82 x 11 days 4.5 days	$48,118.92
2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($48,118.92)	$8,019.82
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 – 1.00	0.00
2d	Determine the IPPS comparable per diem amount portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable per diem amount determined in step (2-b)	0.00 x $8,019.82	$0.00
3	Compute the blend alternative	Add the 120 percent of the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$37,218.93 + $0.00	$37,218.93**

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

** Note that, since in this example the LOS of the SSO case exceeds 25 days, the blend percentage applicable to the 120 percent of the LTC-DRG specific per diem amount is 100 percent and the percentage applicable to the IPPS comparable per diem amount is 0 percent, therefore the amount computed under the blend option is equal to 120 percent of the LTC-DRG specific per diem amount.

Under the blend alternative of the SSO payment formula, an amount comparable to what would otherwise be paid under the IPPS (i.e., full IPPS comparable amount) includes payment for the costs of inpatient operating services based on the standardized amount determined under §412.64(c), adjusted by the applicable DRG weighting factors determined under §412.60 as specified at §412.64(g). This amount is further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at §412.525(c) and using the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. (In the RY 2006 LTCH PPS final rule (70 FR 24200), we discuss the inapplicability of geographic reclassification procedures for LTCHs.) For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (Currently, the same COLA factors are used under both the IPPS and the LTCH PPS.)

Additionally, an amount comparable to what would be paid under the IPPS for the case includes a disproportionate share (DSH) adjustment (see §412.106), if applicable, and includes an indirect medical education (IME) adjustment (see §412.105), if applicable. For the comparable IPPS DSH adjustment, provider specific file elements 24 (Bed Size), 27 (Supplemental Security Income Ratio (SSI)), and 28 (Medicaid Ratio) are required, as discussed below. In determining a LTCH's SSI ratio and Medicaid ratio used in the calculation of the comparable IPPS DSH adjustment, refer to sections 20.3.1.1 and 20.3.1.2 of this manual.

For the comparable IPPS IME adjustment, provider specific file elements 23 (Intern/Beds Ratio) and 49 (Capital Indirect Medical Education Ratio) are required, as discussed below. Furthermore, the IPPS comparable IME adjustment for a LTCH is determined by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCH's direct GME cap as set forth at §413.79(c)(2) (which will already be established for a LTCH which had residency programs). In determining the IPPS comparable IME adjustment for a LTCH, if applicable, the use of a proxy for the IME cap is necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. The full IPPS comparable amount used under the blend alternative in the SSO payment adjustment, also includes payment for inpatient capital-related costs, based on the capital Federal rate at §412.308(c), which is adjusted by the applicable IPPS DRG weighting factors. This amount is further adjusted by the applicable geographic adjustment factors set forth at §412.316, including wage index (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals as published in the annual IPPS final rule), and large urban location, if applicable. A LTCH PPS payment amount comparable to what would be paid under the IPPS does not include additional payments for extraordinarily high cost cases under the IPPS outlier policy (§412.80(a)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS high cost outlier payment at §412.525(a)(1) (i.e., if the estimated costs of the case exceeds the adjusted LTCH PPS SSO payment plus the fixed-loss amount) will receive an additional payment under the LTCH PPS HCO high cost outlier at §412.525(a) (67 FR 56026; August 30, 2002). Under the revised SSO payment formula, we will continue to use the fixed-loss amount calculated under §412.525(a), and not a fixed-loss amount based on §412.80(a), to determine whether a SSO case receives an additional payment as a high cost outlier case.

For RY 2008, the SSO policy was revised as follows:

Effective for LTCH PPS discharges occurring on or after July 1, 2007, and on or before December 28, 2007*, the payment adjustment formula for SSO cases was revised for those cases where the patient's LTCH covered LOS is less than, or equal to an "IPPS-comparable" threshold. For cases falling within this "IPPS-comparable" threshold, Medicare payment under the SSO policy is subject to an additional adjustment.

The IPPS-comparable threshold is defined as the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY 2008 final rule (72 FR 26870 at 27019- 27029)).

If the covered LOS at the LTCH is less than or equal to the IPPS-comparable threshold for the LTC-DRG, Medicare payment is based on the IPPS comparable per diem amount, capped at the full IPPS comparable amount. This option replaces the "blend" amount in the adjusted LTCH PPS SSO payment formula.

Effective for discharges occurring on or after July 1, 2007 and on or before December 28, 2007*, therefore, the adjusted Medicare payment for an SSO case where the covered LOS at the LTCH is within the IPPS-comparable threshold, is equal the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- the "IPPS comparable" per diem amount , capped at the full IPPS comparable amount

The IPPS comparable amount is determined by the same methodology as the IPPS comparable portion of the blend alternative, specified above in the above examples at 2a.

For SSO cases where the covered length of stay exceeds the "IPPS threshold," payment is made under the SSO payment formula that became effective beginning in RY 2007, as specified above.

***NOTE:** On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the SSO payment adjustment formula for a 3-year period beginning on the date of enactment of the Act. Specifically, section 114(c)(3) of the MMSEA specifies that the revision to the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Consequently, the fourth option in the SSO payment adjustment formula at §412.529(c)(3)(i) will not apply during this 3-year period, and therefore, there will be no comparison of the covered LOS of the SSO case to the "IPPS threshold" in determining the payment adjustment for SSO cases. Therefore, for SSO discharges occurring on or after December 29, 2007, and before December 29, *2012*, the adjusted payment for a SSO case is equal to the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

As noted above, during this 3-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the "IPPS threshold") are paid under the SSO payment formula that became effective beginning in RY 2007, as described above.

Short Stay Outlier Policy for LTCHs qualifying under §1886(d)(1)(B)(II)

A "subsection (II)" hospital:

- Was excluded as a LTCH in 1986
- Has an average inpatient LOS of greater than 20 days, and
- Demonstrates that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending FFY 1997 have a principal finding of neoplastic disease.

For a "subsection (II)" hospital there is a special short-stay outlier policy effective for the remainder of the transition period (i.e., **discharges** occurring on or after July 1, 2003 through December 31, 2006), where the lesser of 120 percent of cost or120 percent of the per diem LTC-DRG in the existing short-stay outlier policy is replaced with the follow percentages:

- Effective for **discharges** occurring on or after **July 1, 2003 through the first year of transition 195%**;
- Effective for **discharges** during the second year of the transition, **193%**;
- Effective for **discharges** during the third year of the transition, **165%**;
- Effective for **discharges** during the fourth year of the transition, **136%**; and
- Effective for **discharges** for the last year and thereafter, the percentage returns to **120%**.

150.9.1.4 - Payment Policy for Co-Located Providers

(Rev. 2060, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

Hospitals within hospitals (HwH), satellite facilities, and onsite SNFs:

The LTCHs that are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs) are subject to the interrupted stay policy (§150.9.1.2) but in addition, if such discharges and readmissions exceed 5 percent of the LTCH's total discharges during a cost reporting period, **all** such readmissions during that cost reporting period are to be paid as one discharge, regardless of the time spent at the intervening facility.

- One 5 percent calculation is applied to discharges to and readmissions from onsite acute care hospitals and a separate 5 percent calculation is made for the combined discharges to, and readmissions to, the LTCH from onsite IRFs, SNFs, and psychiatric facilities.)

- Prior to triggering either of the 5 percent thresholds, such cases are to be evaluated and paid under the interrupted stay policy. (Presently, there is no interrupted stay policy for psychiatric facilities, so in the case of a LTCH patient who is directly readmitted from a psychiatric facility, there will be two LTC-DRG payments unless, and until, the number of such readmissions (counted along with readmissions from an onsite IRF or SNF) reach the 5 percent threshold.)

The LTCHs were required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that began on or after October 1, 2002. A change in co-located status must be reported to the FIs within 60days of such a change. The implementation of the onsite policy is based on information maintained by FIs on other Medicare providers co-located with LTCHs. FIs notify the CMS RO of such arrangements.

Payments under this policy are determined at cost report settlement.

Beginning FY 2005, an additional payment adjustment was established for LTCH HwHs and satellites of HwHs relating to the percentage of patients discharged during a specific cost reporting period that were admitted from their host hospital. Effective for cost reporting periods beginning on or after July 1, 2007, the payment adjustment that governs LTCH HwHs and satellites of HwHs discharging patients from their host hospital was extended to govern discharges from all LTCHs (not already addressed by the existing policy) that are admitted from any referring hospital. This policy adjustment includes discharges from "grandfathered" LTCH HwHs and LTCH satellites that were admitted from their host hospitals; LTCH and LTCH satellite discharges from referring hospitals that are not co-located with the discharging facility; and discharges from "free-standing" LTCHs that were admitted from any referring hospital.

Basic Payment Formula under the 25 Percent Threshold Payment Adjustment for Medicare Discharges from Referring Hospitals

NOTE: On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted with mandated several modifications to this policy for a 3-year period beginning on the date of enactment of the Act. For clarity, each modification to the policy is specified in a bullet point immediately below the explanation of the particular aspect of the policy as it was effective on July 1, 2007. The bullet points below also include additional amendments made by the enactment of the American Recovery and Reinvestment Act (ARRA) of 2009 on February 17, 2009, to the 25 percent threshold payment adjustment. It is important to note that for those policies that operate on an October 1 cycle (i.e. pre-MMSEA regulations at 42 CFR §412.534), the ARRA has amended the MMSEA so that the MMSEA relief is effective for cost reporting periods beginning on or after October 1, 2009, and before October 1, 2010. For policies that operate on a July 1 cycle, (e.g., pre-MMSEA regulations at 42 CFR 412.534(h) and §412. 536) the ARRA amendments to the MMSEA relief are effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.

With the passage of the Affordable Care Act of 2010, all provisions of MMSEA as amended by the ARRA affecting the LTCH PPS were extended an additional 2-years. Therefore, provisions

due to sunset on July 1, 2010, and October 1, 2010, have been extended until July 1 2012, and October 1, 2012, respectively. The revisions to this section (below), indicate these new dates.

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**
  - This policy was finalized for FY 2005

- If a LTCH HwH or satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS. For LTCHs and LTCH satellites subject to the transition period described below, there is a 3-year transition to the full 25 percent threshold payment adjustment.

  As amended by the MMSEA of 2007 and *further amended by the ARRA and the ACA:*

  - The percentage threshold for "applicable" LTCHs and LTCH satellites (i.e., subject to the transition described below) is raised from 25 percent to 50 percent for LTCH cost reporting periods beginning on or after October1, 2007, and before October 1, *2012*. "Grandfathered" LTCH satellites are also "applicable" for this increase, under the ARRA but on a July 1 cycle, as noted above.

  - For LTCHs with "special circumstances," specified below, the 50 percent threshold is raised to 75 percent for the same 3-year period.

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to Grandfathered LTCH HwHs and LTCH Satellites from their Host Hospitals**

  Prior to the enactment of the MMSEA and the ARRA, this policy was effective for cost reporting periods beginning on or after July 1, 2007.

  - Subject to the 3-year transition described below, if a grandfathered LTCH HwH or a grandfathered satellite of a LTCH has admitted from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS.

- In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to all LTCHs and LTCH Satellites from Referring Hospitals other than those with which they are Co-located:**

  - This policy is effective for cost reporting periods beginning on or after July 1, 2007.

  - Subject to the 3-year transition specified below, if a LTCH or LTCH satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS. (See details of this payment adjustment below the discussion of the MMSEA and the ARRA changes.)

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

As amended by the MMSEA of 2007 and *further amended by the ARRA and the ACA:*

- For cost reporting periods beginning on or after July 1, 2007, and before July 1, *2012*, grandfathered LTCH HwHs are exempted from the 25 percent threshold for admissions from co-located hospitals or referring hospitals with which they are not co-located.

- "Freestanding" LTCHs, i.e., LTCHs not co-located with another hospital as a HwH or as a satellite are exempted from the 25 percent threshold for admissions from any referring hospital.

As amended by the ARRA of 2009:

- The ARRA amended the MMSEA changes to the 25 percent threshold policy by adding another category of LTCHs that would be subject to the 3-year delay in application of the 25 percent payment provision, i.e., LTCHs or LTCH satellites

that were co-located with provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located.

The *5*-year delay in the application of the percentage threshold payment adjustment for each of the above categories is effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, *2012*.

NOTE: For cost reporting periods beginning on or after July 1, 2007 and before July 1, *2012* or on or after October 1, 2007, and before October 1, *2012*, as applicable (see explanation above), this payment adjustment continues to be applicable under the specific circumstances set forth in the MMSEA and the ARRA *as amended by the ACA*.

Payment adjustment under the 25 percent threshold payment policy

Under the LTCH PPS, payments for LTCH or LTCH discharges in excess of the specified threshold percentages are based on the lesser of an amount otherwise payable under the LTCH PPS or an amount that is equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would be based on the standardized amount adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted for area wage levels using the applicable IPPS labor-related share based on the CBSA where the LTCH is physically located and the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. For LTCHs located in Alaska and Hawaii, this amount would also be adjusted by the applicable COLA factors used under the IPPS. Furthermore, an amount equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would also include, where applicable, a DSH adjustment and where applicable, an IME adjustment.

Additionally, to arrive at the payment amount equivalent to what would otherwise be payable under the IPPS, a LTCH would also be paid under the LTCH PPS for the costs of inpatient capital-related costs, using the capital Federal rate determined under adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted by the applicable geographic adjustment factors set forth, including local cost variation (based on the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule), large urban location, and COLA, if applicable.

For discharges governed by this payment, an amount that is equivalent to an amount that would otherwise be paid under the IPPS for the inpatient capital-related costs would also include a DSH adjustment if applicable, and an equivalent IME adjustment), if applicable.

An amount equivalent to what would be paid under the IPPS would be determined based on the sum of the amount equivalent to what would be paid under the IPPS inpatient operating services and the amount equivalent to what would be paid under the IPPS for inpatient capital-related costs. This is necessary since, under the IPPS, there are separate Medicare rates for operating and capital costs to acute care hospitals, while under the LTCH PPS, there is a single payment rate for the operating and capital costs of the inpatient hospital's services provided to LTCH Medicare patients.

Note that there is a difference between the policy that we have codified for adjusted payments to LTCH HwHs and satellites of LTCHs, which is based on an amount "equivalent" under the existing payment, and the additional component to the SSO payment adjustment that is based on an amount "comparable" to what would otherwise be paid under the IPPS adjustment. The distinction is that if a SSO case also qualifies as a high cost outlier (HCO) case after the SSO payment amount is determined, the SSO payment formula uses the LTCH PPS fixed loss amount. In contrast, under the payment adjustment for LTCH HwHs and LTCH satellites if the amount payable by Medicare for a specific case is equivalent to what would be otherwise payable under the IPPS and the case also qualified as a HCO, the outlier payment for this case would be based on the IPPS HCO policy because the resulting payment would then be more equivalent to what would have been payable under the IPPS. Similarly, if under this payment adjustment the lesser amount resulted in an "otherwise payable amount under the LTCH PPS," and the stay qualified as a HCO, Medicare would generate a HCO payment governed by the LTCH PPS fixed loss amount calculated under the LTCH PPS and if the estimated cost of the case exceeds the adjusted LTC-DRG plus a fixed loss amount under §412.525(a), the LTCH would receive an additional payment based on the LTCH PPS HCO policy.

Specific Circumstances (applicable to all of the above scenarios)

NOTE: MMSEA changes described above, *as amended by the ARRA and further amended by the ACA, are* applicable for cost reporting periods beginning on or after October 1, 2007, and before October 1, *2012*, or *on or after* July 1 2007, and before July 1, *2012*..

- For LTCHs and LTCH satellites located in rural areas, instead of the 25 percent threshold, we provide for a 50 percent threshold for patients from any individual referral hospital. In addition, in determining the percentage of patients admitted from that referring hospital, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital. Under MMSEA, the 25 percentage threshold is increased to 50 percent for applicable LTCH HwHs, satellites, and grandfathered satellites.

- For urban single or MSA dominant referring hospitals, we would allow the LTCH or LTCH satellite to admit from the host up to the referring hospital's percentage of total Medicare discharges in the MSA. A floor of 25 percent and a ceiling of 51 percent applied to this variation. Under MMSEA, the 50 percentage threshold is increased to 75 percent.

Transition Periods

For Medicare discharges from referring hospitals:

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**

- This policy was finalized for FY 2005.

This payment adjustment will be phased-in over 4 years for existing LTCH HwHs and also for LTCHs-under-formation that satisfy the following two-prong requirement:

- On or before October 1, 2004 they have certification as acute care hospitals, under Part 489; and

- Before October 1, 2005 designation as a LTCH.

For purposes of full payment under the LTCH PPS during the transition period, the percentage of discharges from the LTCH HwH originating from the host hospital for each applicable cost reporting period, may not exceed the percentage of discharges during the hospital's cost reporting period during FY 2004 that were admitted from the host hospital.

Year 1 -- (cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) a "hold harmless"

- Payments will be made under the LTCH PPS but the percentage of LTCH HwH discharges originating from the host may not exceed the percentage for such patients established for cost reporting periods during FY 2004.

Year 2 -- (cost reporting periods beginning on or after October 1, 2005 through September 30, 2006)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 75 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 -- (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 50 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 4 -- (cost reporting periods beginning on or after October 1, 2007 through September 30, 2008)

- o LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent or the applicable percentage described for "specific circumstances above."
- o For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Transition Period for all LTCHs affected by the Above Described Regulations for cost reporting periods beginning on or after July 1, 2008.

NOTE: MMSEA *as amended by the ARRA and further amended by the ACA* changes described above applicable for cost reporting periods beginning on or after July 1, 2007, and before July 1, *2012* for "grandfathered" LTCH HwHs and "freestanding" LTCHs.

The full payment threshold adjustment will be phased in over 3-years as follows:

Year 1 - (for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008)

- o LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 75 percent.
- o For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 2 - (for cost reporting periods on or after July 1, 2008 through June 30, 2009),

- o LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 50 percent.
- o For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 - (for cost reporting periods on or after July 1, 2009)

- o All LTCHs and LTCH satellites subject to the payment threshold policy effective for RY 2008, will be subject to the 25 percent (or applicable percentage) threshold.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Implementation:

- The payment threshold policy for discharges from co-located LTCH HwHs and LTCH satellites admitted from their hosts (including grandfathered LTCH HwHs and satellites) is determined based on a location-specific basis.

- The payment threshold policy for discharges from LTCHs and LTCH satellites admitted from referring hospitals with which they are not co-located is determined based upon provider numbers for both the LTCH and the referring hospital.

For LTCHs and LTCH satellites subject to both the FY 2005 and the RY 2008 threshold payment adjustment policies

- If a co-located LTCH or a co-located referring hospital (host) shares a provider number with a hospital or satellite at another location, threshold determinations will continue to be location-specific for the co-located LTCH and host. The threshold percentage determinations will be applied to all other location or campus of either a LTCH or referring hospital in the aggregate. For example, when the policy finalized for RY 2008 is fully phased in, a co-located LTCH (LTCH A) and host (referring hospital A) will have a 25 percent threshold under the policy finalized for FY 2005. If referring hospital A shares a provider number with a remote location (RH A'), then another 25 percent threshold will be applied to patients discharged from LTCH A that were admitted RH A'.

- We note that for cost reporting periods beginning on or after October 1, 2007, non-grandfathered co-located LTCHs, are fully phased-in to the full 25 percent (or applicable percentage threshold) for discharges admitted from their co-located hosts (under the initial 25 percent payment threshold established for FY 2005)s.

- However, for discharges admitted from non-co-located referring hospitals, these LTCH HwHs and satellites are governed by the policy finalized for RY 2008. Therefore, for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008, the 75 percent threshold will apply, and the 50 percent threshold will apply for cost reporting periods beginning on or after July 1, 2008 through June 30, 2009 as described above in this response.)

- Furthermore, under our finalized policy for RY 2008, grandfathered LTCH HwHs and satellites will be subject to the 3-year transition that we are finalizing under this new policy for all their discharges, both admitted from their co-located host and from other non-co-located referring hospitals.

When both policies apply:

If a patient discharged from a LTCH HwH or satellite was originally admitted from the host hospital and immediately prior to that admission to the host, the patient was being treated at the same LTCH HwH or LTCH satellite, both of the policies described in this section, the 5 percent on-site policy as well as the 25 percent policy are applicable. In such a case, the following procedures should be followed keeping in mind that the 5 percent rule affects number of discharges and the 25 percent rule affects payment.

- The on-site 5 percent computation is first in order to determine the real number of discharges.

- Focusing on the relationship between an acute host and a LTCH HwH/satellite, if the number of revolving door discharges between these two facilities exceeds 5 percent during a CR period, this policy will collapse the number of discharges within that CR period, halving the # of revolving door LTCH stays where the intervening stay exceeded the threshold and eliminating from consideration those host stays that were bracketed by two LTCH stays. All such stays for the entire cost reporting period will be paid as one LTCH PPS stay.

- The next issue is to determine which of these stays will be paid an unadjusted LTCH PPS rate and which will be paid an amount equivalent to what would otherwise be paid under the IPPS. Cases prior to tripping the 25 percent threshold will be paid the otherwise unadjusted LTCH PPS rate and those after the threshold that had not achieved outlier status at the host it will be paid based on the adjustment.

- Because of the 5 percent policy that collapsed the discharges from the LTCH, for purposes of the 25 percent policy, we are focusing on fewer discharges in total from the LTCH and we need to determine what percent of these discharges originated in the host so that we can apply the payment adjustment.

BUT, in the event that the 5 percent is not tripped during that cost reporting period, each acute-->LTCH-->acute--> LTCH cycle, which will count as two LTCH discharges originating in the host for purposes of the 25 percent policy, since both the first and second LTCH admission were from the host.

PROV	FY2011WA
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010010	0.7762
010012	0.7613
010015	0.7491
010021	0.7488
010027	0.7462
010032	0.7745
010040	0.7497
010045	0.7811
010047	0.7702
010049	0.7462
010091	0.7491
010109	0.7841
010110	0.7886
010125	0.7861
010128	0.7491
010129	0.7589
010138	0.7525
010150	0.7702
030067	0.9376
040019	0.7732
040047	0.7516
040067	0.7525
040081	0.7877
050007	1.5582
050070	1.5582
050113	1.5582
050133	1.2101
050289	1.5582
050298	1.1881
050325	1.1917
050444	1.2398
050754	1.5582
060121	0.9757
080001	1.0767
080003	1.0767
090001	1.0561
090003	1.0561
090004	1.0561
090005	1.0561
090006	1.0561
090008	1.0561
090011	1.0561
110100	0.8568
110101	0.7817
110142	0.7939
110205	0.8213
130024	0.8237
130066	0.9535
140001	0.8659
140026	0.8640

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150022	0.8609
150072	0.8451
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160030	1.0012
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180064	0.8169
180066	0.8491
180070	0.8080
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190034	0.8070
190044	0.8129
190050	0.7970
190053	0.8021
190054	0.7984
190078	0.8070
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190184	0.7989
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190246	0.7989
200032	0.8913
210001	0.9553
210023	1.0188
210028	0.9641
210043	1.0188
210061	0.9446
220002	1.1675
220011	1.1675
220025	1.1225
220049	1.1675
220063	1.1675
220070	1.1675
220082	1.1675
220084	1.1675
220098	1.1675
220101	1.1675
220105	1.1675
220171	1.1675
220175	1.1675
230005	0.9050
230015	0.8875
230041	0.9433
230075	0.9776
230092	0.9419
230093	0.8649
230217	0.9776

240018	1.0022
240044	0.9832
240064	0.9327
240101	0.9246
240117	0.9714
240211	1.0138
250128	0.8130
250162	0.8805
260059	0.8163
260064	0.8157
260097	0.8477
260160	0.8263
260163	0.8213
320011	0.9300
330010	0.8361
330033	0.8515
330047	0.8361
330103	0.8435
330132	0.8435
330135	1.1875
330144	0.8338
330151	0.8338
330175	0.8555
330205	1.1875
330222	0.8680
330264	1.1875
330276	0.8325
340020	0.8597
340024	0.8577
340038	0.8763
340070	0.9033
340133	0.8694
340151	0.8518
360002	0.8650
360040	0.9003
360044	0.8685
360070	0.8587
360071	0.8629
360084	0.8587
360096	0.8569
360107	0.8721
360131	0.8587
360151	0.8587
360156	0.8721
360161	0.8608
360185	0.8569
360355	0.9051
360356	0.8721
370023	0.8092
370065	0.8123
370156	0.8117
370169	0.8194

370214	0.8117
380022	1.0167
390008	0.8532
390039	0.8558
390052	0.8539
390056	0.8543
390112	0.8558
390117	0.8529
390150	0.8526
390173	0.8558
390201	0.9466
420002	0.9255
420005	0.8406
420007	0.9194
420019	0.8563
420043	0.8568
420053	0.8504
420054	0.8395
420055	0.8425
420062	0.8518
420082	0.9555
420083	0.9194
420098	0.8401
430048	1.0353
430094	1.0353
440007	0.8142
440008	0.8212
440012	0.7972
440016	0.8043
440017	0.7972
440047	0.8151
440050	0.7972
440051	0.8008
440060	0.8151
440063	0.7996
440070	0.8023
440105	0.7996
440109	0.8002
440115	0.8151
440137	0.8568
440148	0.8205
440176	0.7972
440181	0.8269
440182	0.8043
440184	0.7996
450090	0.8687
450163	0.8092
450192	0.8292
450194	0.8029
450210	0.8104
450236	0.8402
450270	0.8292

450395	0.8448
450451	0.8500
450460	0.8032
450497	0.8492
450539	0.8115
450573	0.8109
450597	0.7980
450615	0.8009
450641	0.8492
450698	0.8240
450755	0.8551
450813	0.8007
450888	0.9438
460001	0.9204
460013	0.9204
460017	0.8899
460023	0.9204
460043	0.9204
460052	0.9204
490002	0.8025
490038	0.8025
490084	0.8258
490105	0.8025
490110	0.8429
500019	1.0234
500024	1.1036
500139	1.1036
500143	1.1036
510012	0.7649
520009	0.9328
520035	0.9365
520044	0.9365
520045	0.9488
520048	0.9488
520057	0.9468
520088	0.9423
520102	0.9799
520160	0.9328
520198	0.9488
670023	0.9438
670042	0.9438
670046	0.9438

Attachment B - Hospitals Not Receiving Annual Payment Update (APU) - FY 2011

State	Hospital CCN	Hospital Name
AL	010112	BRYAN W WHITFIELD MEM HOSP INC
AZ	030084	CHINLE COMPREHENSIVE CARE FACILITY
AZ	030127	WESTERN REGIONAL MEDICAL CENTER CANCER HOSPITAL
AR	040091	MEDICAL PARK HOSPITAL
AR	040152	PHYSICIANS SPECIALTY HOSPITAL
CA	050091	COMMUNITY AND MISSION HOSPITAL OF HUNTINGTON PARK
CA	050205	EAST VALLEY HOSPITAL MEDICAL CENTER
CA	050349	CORCORAN DISTRICT HOSPITAL
CA	050423	PALO VERDE HOSPITAL
CA	050547	SONOMA DEVELOPMENTAL CENTER
CA	050682	KINGSBURG MEDICAL CENTER
CA	050754	MENLO PARK SURGICAL HOSPITAL
CO	060043	KEEFE MEMORIAL HOSPITAL
FL	100139	NATURE COAST REGIONAL HOSPITAL
FL	100240	ANNE BATES LEACH EYE HOSPITAL
HI	120004	WAHIAWA GENERAL HOSPITAL
IL	140033	VISTA MEDICAL CENTER WEST
KS	170150	SOUTH CENTRAL KS REGIONAL MED CENTER
LA	190090	WINN PARISH MEDICAL CENTER
LA	190099	AVOYELLES HOSPITAL
LA	190106	OAKDALE COMMUNITY HOSPITAL
MS	250079	SHARKEY ISSAQUENA COMMUNITY HOSPITAL
MS	250149	PIONEER COMMUNITY HOSPITAL OF NEWTON
NE	280119	P H S INDIAN HOSPITAL
NM	320037	CIBOLA GENERAL HOSPITAL
NM	320060	ZUNI COMPREHENSIVE COMMUNITY HEALTH CENTER
NC	340049	NORTH CAROLINA SPECIALTY HOSPITAL
NC	340156	CHEROKEE INDIAN HOSPITAL AUTHORITY
ND	350064	P H S INDIAN HOSPITAL AT FORT YATES-STANDING ROC
OH	360247	WOODS AT PARKSIDE,THE
OK	370199	LAKESIDE WOMEN'S HOSPITAL

OK	370206	OKLAHOMA SPINE HOSPITAL
OK	370225	FOUNDATON BARIATRIC HOSPITAL IN EDMOND
PA	390321	SURGICAL SPECIALTY CENTER AT COORDINATED HEALTH
PA	390322	BUCKS COUNTY SPECIALTY HOSPITAL
SD	430084	ROSEBUD IHS HOSPITAL
TX	450283	COZBY-GERMANY HOSPITAL
TX	450422	BAYLOR MEDICAL CENTER AT UPTOWN
TX	450446	RIVERSIDE GENERAL HOSPITAL
TX	450565	PALO PINTO GENERAL HOSPITAL
TX	450683	RENAISSANCE HOSPITAL TERRELL
TX	450880	BAYLOR SURGICAL HOSPITAL AT FORT WORTH
TX	670057	FOREST PARK MEDICAL CENTER
TX	670062	MAGNOLIA MEDICAL CENTER