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(1) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments as provided in §412.525 and payments for hemophilia clotting factor costs as provided in paragraph (b)(2)(iii) of this section, are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Other payments for the direct costs of approved medical education programs, bad debts, anesthesia services furnished by hospital employed nonphysician anesthetists, and costs of photocopying and mailing medical records to the QIO as provided for under paragraphs (b)(2)(i), (ii), (iv), and (v) of this section are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

(e) *Special payment provisions for patients in acute care hospitals that change classification status to LTCH status during a patient stay.* (1) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at §412.23(e) to be paid as a LTCH during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under this subpart. The requirements of this paragraph (e)(1) apply only to a

patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(2) The days of the patient's stay prior to and after the hospital's designation as a LTCH as specified in paragraph (e)(1) of this section are included for purposes of determining the beneficiary's length of stay.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003; 69 FR 49250, Aug. 11, 2004; 70 FR 47487, Aug. 12, 2005]

§412.523 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the initial prospective payment rates for inpatient hospital services furnished by long-term care hospitals, CMS uses—

(1) The best Medicare data available; and

(2) A rate of increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient long-term care hospital services.

(b) *Determining the average costs per discharge for FY 2003.* CMS determines the average inpatient operating and capital-related costs per discharge for which payment is made to each inpatient long-term care hospital using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to FY 2003 by a rate of increase factor, described in paragraph (a)(2) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(c) *Determining the Federal prospective payment rates.* (1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard Federal rate. The standard Federal rate is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(2) of this section to each

hospital's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for FY 2003. Based on the updated cost per discharge, CMS estimates the payments that would have been made to each hospital for FY 2003 under Part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard Federal rate.* The standard Federal rate is computed as follows:

(i) *For FY 2003.* Based on the updated costs per discharge and estimated payments for FY 2003 determined in paragraph (c)(2) of this section, CMS computes a standard Federal rate for FY 2003 that reflects, as appropriate, the adjustments described in paragraph (d) of this section. The FY 2003 standard Federal rate is effective for discharges occurring in cost reporting periods beginning on or after October 1, 2002 through June 30, 2003.

(ii) *For long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006.* The standard Federal rate for long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year, updated by the increase factor described in paragraph (a)(2) of this section, and adjusted, as appropriate, as described in paragraph (d) of this section. For the rate year from July 1, 2003 through June 30, 2004, the updated and adjusted standard Federal rate is offset by a budget neutrality factor to account for updating the FY 2003 standard Federal rate on July 1 rather than October 1.

(iii) *For long-term care hospital prospective payment system rate year beginning July 1, 2006 and ending June 30, 2007.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2006 and ending June 30, 2007 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by zero percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(4) *Determining the Federal prospective payment rate for each LTC-DRG.* The Federal prospective payment rate for each LTC-DRG is the product of the weighting factors described in §412.515 and the standard Federal rate described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard Federal rate.* The standard Federal rate described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in §412.525(a).

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been paid to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart, excluding the effects of sections 1886(b)(2) and (b)(3) of the Act.

(3) *One-time prospective adjustment.* The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates on or before July 1, 2008, so that the effect of any significant difference between actual payments and estimated payments for the first year of the long-term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, a long-term care hospital's Federal prospective payment is computed on the basis of the Federal prospective payment rate multiplied by the relative weight of the LTC-DRG assigned for that discharge. A hospital's Federal prospective payment rate will be adjusted, as appropriate, to account

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for outliers and other factors as specified in § 412.525.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003; 71 FR 27899, May 12, 2006]

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.*

(1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC-DRG payment plus a fixed-loss amount. For each long-term care hospital rate year, CMS determines a fixed-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs.

(2) The fixed-loss amount is determined for the long-term care hospital rate year using the LTC-DRG relative weights that are in effect on July 1 of the rate year.

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the adjusted LTCH PPS Federal prospective payment and the fixed-loss amount.

(4)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(1) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(2) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean cost-to-charge ratio. CMS establishes and publishes this mean annually.

(3) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

(b) *Adjustments for Alaska and Hawaii.* CMS adjusts the Federal prospective payment for the effects of a higher cost