

of living for hospitals located in Alaska and Hawaii.

(c) *Adjustments for area levels.* The labor portion of a long-term care hospital's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS), which reflects the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined in accordance with paragraph (c)(1) or (c)(2) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The appropriate wage index (established by CMS) is updated annually.

(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, the application of the wage index under the long-term care hospital prospective payment system is made on the basis of the location of the facility in an urban or rural area as defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively.

(2) For discharges occurring on or after July 1, 2005, the application of the wage index under the long-term care hospital prospective payment system is made on the basis of the location of the facility in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C).

(d) *Special payment provisions.* CMS adjusts the Federal prospective payment to account for—

(1) Short-stay outliers, as provided for in § 412.529; and

(2) A 3-day or less interruption of a stay and a greater than 3-day interruption of a stay, as provided for in § 412.531.

(3) Patients who are transferred to onsite providers and readmitted to a long-term care hospital, as provided for in § 412.532.

(4) Long-term care hospitals-within-hospitals and satellites of long-term care hospitals as provided in § 412.534.

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§ 412.529 Special payment provision for short-stay outliers.

(a) *Short-stay outlier defined.* “Short-stay outlier” means a discharge with a length of stay in a long-term care hospital that is up to and including five-sixths of the geometric average length of stay for each LTC-DRG.

(b) *Adjustment to payment.* CMS adjusts the hospital's Federal prospective payment to account for any case that is determined to be a short-stay outlier, as defined in paragraph (a) of this section, under the methodology specified in paragraph (c) of this section.

(c) *Method for determining the payment amount.* (1) For discharges from long-term care hospitals described under § 412.23(e)(2)(i), occurring before July 1, 2006, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section;

(ii) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(iii) The Federal prospective payment for the LTC-DRG determined under paragraph (d)(3) of this section.

(2) For discharges occurring on or after July 1, 2006, from long-term care hospitals described under § 412.23(e)(2)(i), the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section;

(ii) 100 percent of the estimated cost of the case determined under paragraph (d)(2) of this section;

(iii) The Federal prospective payment for the LTC-DRG as determined under paragraph (d)(3) of this section; or

(iv) An amount payable under subpart O computed as a blend of an amount comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4)(i) of this section and

the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section.

(A) The blend percentage applicable to the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the LTC–DRG or 25 days, not to exceed 100 percent.

(B) The blend percentage of the amount determined under paragraph (d)(4)(i) of this section is determined by subtracting the percentage determined in paragraph (A) from 100 percent.

(3)(i) For discharges occurring on or after October 1, 2002, and before August 8, 2003, no reconciliations are made to short-stay outlier payments upon cost report settlement to account for differences between 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, short-stay 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, short-stay 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, short-stay outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (c)(3)(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. This 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. 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 (c)(3)(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.

(d) *Calculation of alternative payment amounts.* (1) *Determining the LTC–DRG per diem amount.* CMS calculates the LTC–DRG per diem amount for short-stay outliers for each LTC–DRG by dividing the product of the standard Federal payment rate and the LTC–DRG relative weight by the geometric average length of stay of the specific LTC–DRG multiplied by the covered days of the stay.

(2) *Determining the estimated cost of a case.* To determine the estimated cost of a case, CMS multiplies the hospital-specific cost-to-charge ratio by the Medicare allowable charges for the case.

(3) *Determining the Federal prospective payment for the LTC-DRG.* CMS calculates the Federal prospective payment for the LTC-DRG by multiplying the adjusted standard Federal payment rate by the LTC-DRG relative weight.

(4) *Determining the amount comparable to the hospital inpatient prospective payment system per diem amount.* (i) *General.* Under Subpart O, CMS calculates—

(A) An amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge.

(B) An amount comparable to the hospital inpatient prospective payment system per diem amount for each DRG that is determined by dividing the amount that would otherwise be paid under the hospital inpatient prospective payment system computed under paragraph (A) of this section by the hospital inpatient prospective payment system geometric average length of stay of the specific DRG multiplied by the covered days of the stay.

(C) For purposes of the blend amount described in paragraph (c)(2)(iv) of this section, the payment amount specified under subparagraph (B) of this section may not exceed the full amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system determined under subparagraph (A) of this section.

(ii) *Hospital inpatient prospective payment system operating standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(A) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors.

(B) Is adjusted for different area wage levels based on the geographic classifications set forth at § 412.64(b)(1)(ii)(A) through (C) and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applica-

ble hospital inpatient prospective payment system cost of living adjustment factors.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(iii) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(A) Is adjusted for the applicable inpatient prospective payment system DRG weighting factors.

(B) Is adjusted for the applicable geographic adjustment factors, including local cost variation based on the geographic classifications set forth at § 412.64(b)(1)(ii)(A) through (C) and the applicable full hospital inpatient prospective payment system wage index value for non-reclassified hospitals and, applicable large urban location cost of living adjustment factors for LTCHs in Alaska and Hawaii, if applicable.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(e) Short-stay outlier payments to long-term care hospitals described under § 412.23(e)(2)(ii).

(1) For discharges occurring on or after October 1, 2002, through June 30, 2003, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section;

(ii) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(iii) The Federal prospective payment for the LTC-DRG determined under paragraph (d)(3) of this section.

(2) For discharges occurring on or after July 1, 2003, subject to the provisions of paragraph (e)(2)(v) of this section, the adjusted payment amount for a short-stay outlier is determined under the formulas set forth in paragraphs (e)(1)(i) through (iv) of this section with the following substitutions:

(i) For the first year of the transition period, as specified at §412.533(a)(1), the 120 percent specified for the LTC-DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 195 percent.

(ii) For the second year of the transition period, as specified at §412.533(a)(2), the 120 percent specified for the LTC-DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 193 percent.

(iii) For the third year of the transition period, as specified at §412.533(a)(3), the 120 percent specified for the LTC-DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 165 percent.

(iv) For the fourth year of the transition period, as specified at §412.533(a)(4), the 120 percent specified for the LTC-DRG specific per diem amount and 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 136 percent.

(v) For discharges occurring in cost reporting periods beginning on or after October 1, 2006 (beginning with the fifth year of the transition period), as specified at §412.533(a)(5), short-stay outlier payments are made based on the least of the following amounts:

(A) 120 percent of the LTC-DRG specific per diem amount determined under paragraph (d)(1) of this section;

(B) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(C) The Federal prospective payment for the LTC-DRG determined under paragraph (d)(3) of this section.

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§412.531 Special payment provisions when an interruption of a stay occurs in a long-term care hospital.

(a) *Definitions*—(1) *A 3-day or less interruption of stay defined.* “A 3-day or less interruption of stay” means a stay

at a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, IRF, SNF, or the patient’s home and re-admitted to the same long-term care hospital within 3 days of the discharge from the long-term care hospital. The 3-day or less period begins with the date of discharge from the long-term care hospital and ends not later than midnight of the third day.

(2) *A greater than 3-day interruption of stay defined.* “A greater than 3-day or less interruption of stay” means A stay in a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, an IRF, or a SNF for a period of greater than 3 days but within the applicable fixed-day period specified in paragraphs (a)(2)(i) through (a)(2)(iii) of this section before being readmitted to the same long-term care hospital.

(i) For a discharge to an acute care hospital, the applicable fixed day period is between 4 and 9 consecutive days. The counting of the days begins on the date of discharge from the long-term care hospital and ends on the 9th date after the discharge.

(ii) For a discharge to an IRF, the applicable fixed day period is between 4 and 27 consecutive days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 27th day after discharge.

(iii) For a discharge to a SNF, the applicable fixed day period is between 4 and 45 consecutive days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 45th day after the discharge.

(b) *Methods of determining payments.* (1) For purposes of determining a Federal prospective payment—

(i) *Determining the length of stay.* In determining the length of stay of a patient at a long-term care hospital for payment purposes under this paragraph (b)—

(A) Except as specified in paragraphs (b)(1)(i)(B) and (b)(1)(i)(C) of this section, the number of days that a beneficiary spends away from the long-term care hospital during a 3-day or less