



LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM



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Learn about these Long-Term Care Hospital Prospective Payment System (LTCH PPS) topics:

- LTCH classification
- Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) patient classification
- Site neutral payment rate
- Payment policy adjustments
- Payment updates
- LTCH Quality Reporting Program (QRP)
- Resources

LTCH CLASSIFICATION

LTCHs must meet the same Medicare certification requirements as short-term acute care hospitals. LTCHs generally treat medically complex patients who require long-stay hospital-level care. For Medicare payment classification purposes, LTCHs must average an inpatient Length of Stay (LOS) greater than 25 days.

MS-LTC-DRGs PATIENT CLASSIFICATION

The LTCH PPS uses MS-LTC-DRG as a patient classification system. The MS-LTC-DRGs are the same Medicare Severity Diagnosis-Related Groups (MS-DRGs) the Centers for Medicare & Medicaid Services (CMS) uses under the Inpatient Prospective Payment System (IPPS), weighted to reflect the different resources used by LTCH patients. Each patient stay is grouped into an MS-LTC-DRG based on:

- Diagnoses (including secondary diagnoses)
- Procedures performed (up to twenty-five procedures)
- Age
- Gender
- Discharge status

Each MS-LTC-DRG has a predetermined Average Length of Stay (ALOS). CMS annually updates the ALOS based on the latest available LTCH discharge data. Medicare pays an LTCH for each Medicare patient based on the MS-LTC-DRG group if the discharge is excluded from the site neutral payment rate. Medicare pays cases assigned to an MS-LTC-DRG based on the Federal payment rate, including any payment and policy adjustments.



SITE NEUTRAL PAYMENT RATE

For cost reporting periods beginning on or after October 1, 2015, Medicare pays LTCH discharges at a site neutral payment rate when specific patient criteria are not met. The site neutral payment rate is generally the lower of:

- The IPPS equivalent to the per diem amount (calculated under [Short-Stay Outlier](#) [SSO] policy, including any applicable [High-Cost Outlier](#) [HCO] payment)
- The estimated costs of the case calculated by multiplying the allowable charges by the LTCH's Cost-to-Charge Ratio (CCR)

Medicare excludes discharges from the site neutral payment rate and pays based on the standard Federal payment rate if:

- The patient was admitted directly from an IPPS hospital which included at least 3 days in an intensive care unit or coronary care unit but did not have a psychiatric or rehabilitation MS-LTC-DRG in the LTCH
- The patient was admitted directly from an IPPS hospital and got at least 96 hours of respiratory ventilation services in the LTCH but did not have a psychiatric or rehabilitation MS-LTC-DRG in the LTCH

PAYMENT POLICY ADJUSTMENTS

This section discusses the SSO, HCO, fixed-loss amounts, and interrupted stay payment policy adjustments. Unless noted, these policies apply to both site neutral and standard Federal payment rate discharges.

Short-Stay Outlier

The SSO policy helps prevent inappropriate payment for cases without a full episode of care. An SSO payment adjustment is only applicable to the standard Federal payment rate discharges and may occur when a patient:

- Experiences an acute condition that requires urgent treatment or requires more intensive rehabilitation, then is discharged to another facility
- Does not require an LTCH-care-level, then is discharged to another facility
- Discharges to their home
- Dies within the first several days of LTCH admission
- Exhausts benefits during the LTCH stay (explained later in this booklet)

An adjustment applies when the LOS ranges from 1 day through 5/6 of the ALOS for the MS-LTC-DRG the case is grouped to, and MS-LTC-DRG payment is subject to the SSO adjustment.

An adjustment is **not** applied when the LOS is more than 5/6 of the ALOS for the MS-LTC-DRG the case is grouped to, and you get the full MS-LTC-DRG payment.

This policy does not apply to site neutral discharges.

NOTE: If the ALOS for a particular MS-LTC-DRG is 30 days, the SSO policy applies to stays 25 days or less in length (5/6 of 30 days = 25 days).

Before October 1, 2017, Medicare paid an SSO case using the least of one of several case-level adjustment calculation methods. For SSO discharges occurring on or after October 1, 2017, Medicare pays a blend of an amount comparable to what Medicare would otherwise pay under the IPPS, calculated as a per diem and capped at the full IPPS equivalent amount and the MS-LTC-DRG per diem amount.

SSO Payments When Patient’s Benefits Exhaust During an LTCH Stay

Medicare pays for covered benefit days until the LOS triggers a full MS-LTC-DRG payment. In other words, a patient’s remaining number of benefit days and the length of a hospital stay can affect LTCH payment, resulting in an SSO payment adjustment. The following scenarios give examples of SSO payments for patients whose benefits exhaust.

When Benefits Exhaust and LOS Is Below the MS-LTC-DRG Threshold

IF...	THEN...	EXAMPLE...
The patient uses all regular benefit days for an episode during an LOS below the SSO threshold for an MS-LTC-DRG.	The patient is liable for any non-covered days. The LTCH gets an SSO payment for the patient’s covered hospital stay.	The MS-LTC-DRG SSO threshold is 25 days, and the patient’s LOS is 20 days. The LTCH gets an SSO payment. Patient benefit days end on day 15. Medicare pays the LTCH the 15 covered days under the SSO policy. The patient is liable for days 16 through 20.

When Benefits Exhaust and LOS Exceeds the MS-LTC-DRG Threshold

IF...	THEN...	EXAMPLE...
The patient uses all benefit days for an episode during an LOS that exceeds the SSO threshold for an MS-LTC-DRG.	The patient is not liable for any non-covered days. The LTCH gets the full MS-LTC-DRG payment.	The MS-LTC-DRG SSO threshold is 25 days, and the patient’s benefit days end on day 30. The patient’s LOS is 35 days. They are not liable for days 31 through 35 (the SSO policy does not apply). Because the LTCH gets the full MS-LTC-DRG payment, the patient is not liable until the first day the stay qualifies as an HCO.

NOTE: Medicare allows 90 covered benefit days for an episode of care under the inpatient hospital benefit. Each patient has an additional 60 lifetime reserve days. The patient may use these lifetime reserve days to cover additional non-covered days of an episode of care exceeding 90 days.

High Cost Outlier

An HCO is an adjustment to the applicable LTCH PPS payment rate (either the site neutral rate or the standard Federal rate) for LTCH stays that exceed the typical cost for cases with a similar case-mix. It equals 80 percent of the difference between the estimated cost of the case and the outlier threshold and is added to the applicable LTCH PPS payment rate. A standard Federal rate payment is added to the full MS-LTC-DRG payment or the adjusted SSO amount for the case.

To qualify for an HCO payment, an LTCH's estimated treatment costs must exceed the outlier threshold. The applicable outlier threshold is calculated as the applicable LTCH PPS payment for the case plus the applicable fixed-loss amount.

NOTE: Site neutral cases paid based on costs cannot qualify for the HCO adjustment.

Since FY 2016, CMS sets two fixed-loss amounts: one for the site neutral payment rate and one for the standard Federal rate.

The HCO adjustment:

- Improves accuracy of the LTCH PPS in determining patient and hospital resource costs
- Reduces LTCH financial losses resulting from treating patients who need more costly care
- Limits LTCH loss to the fixed-loss amount and the percentage of costs above the marginal cost factor
- Reduces incentive to under-serve high-cost patients

Medicare Administrative Contractors (MACs) use PRICER software to determine HCO claims payments and if there are enough benefit days for each medically necessary day in the outlier period. If a patient has enough benefit days, the MAC processes the claim as usual, and the LTCH takes no other action. If a patient's benefit days exhaust, the MAC returns the claim to the LTCH for correction, indicating the correct HCO threshold amount.

Medicare determines the outlier threshold for SSO cases by adding the fixed-loss amount to the adjusted SSO MS-LTC-DRG payment. If the estimated cost of the SSO case exceeds the HCO threshold, it also qualifies for an HCO payment.

HCO Payments When Patient's Benefits Exhaust During an LTCH Stay

Medicare makes the HCO payment only for:

- Days the patient has Medicare coverage (regular, [coinsurance](#), or lifetime reserve days) for the portion of the stay beyond the HCO threshold
- Covered costs for medically necessary days when the patient has a benefit day available

NOTE: Medicare allows 90 covered benefit days for an episode of care under the inpatient hospital benefit. Each patient has an additional 60 lifetime reserve days. The patient may use these lifetime reserve days to cover additional non-covered days of an episode of care exceeding 90 days.

The following scenarios give examples of HCO payments for patients whose benefits exhaust.

When Patient’s Benefits Exhaust Before Qualifying for Full LTCH PPS Standard Federal Rate Payment

This scenario applies only to LTCH PPS standard Federal rate cases because under the site neutral payment rate calculation, a site neutral patient’s benefits **cannot** exhaust before qualifying for full site neutral rate payment.

IF...	THEN...	EXAMPLE...
<p>The patient’s benefits exhaust before qualifying for the full MS-LTC-DRG payment, and the cost of covered care exceeds the standard Federal rate HCO threshold for the adjusted SSO payment.</p>	<p>The LTCH gets an HCO payment in addition to the SSO adjusted payment for the covered medically necessary benefit days.</p>	<p>An LTCH admits a standard Federal rate patient with 5 remaining benefit days grouped to an MS-LTC-DRG with an ALOS of 30 days. The patient does not have enough regular benefit days to trigger the full MS-LTC-DRG standard Federal rate payment (5/6 of the MS-LTC-DRG ALOS), which qualifies the case for an SSO-adjusted payment. The LTCH cost for covered services during the 5 benefit days exceeds the standard Federal rate HCO threshold. The case also qualifies for an HCO payment for all costs above the HCO threshold for days 1 through 5. The patient is liable for day 6 through discharge.</p>

When Patient’s Benefits Exhaust After Qualifying for Full Applicable LTCH PPS Payment

“Full applicable LTCH PPS payment” refers to the standard Federal rate (including any SSO adjustment) or the site neutral payment rate, based on the LTCH case. “Applicable HCO threshold” refers to the HCO threshold determined from the standard Federal rate fixed-loss amount or the site neutral fixed-loss amount based on the LTCH case.

IF...	THEN...	EXAMPLE...
<p>The patient’s benefits exhaust after qualifying for the full applicable LTCH PPS payment, and the cost of covered care exceeds the applicable HCO threshold.</p>	<p>The LTCH gets an HCO payment in addition to the full LTCH PPS payment for the covered medically necessary benefit days.</p>	<p>An LTCH admits a standard Federal rate patient with 36 remaining benefit days grouped to an MS-LTC-DRG with an ALOS of 30 days. By day 33, the patient’s cost of care exceeds the standard Federal rate HCO threshold, qualifying the case for the full MS-LTC-DRG standard Federal rate payment and an HCO payment for all covered costs (that benefit days are available) above the HCO threshold. The patient is liable for day 37 through discharge.</p>

When Patient’s Benefits Exhaust Before Exceeding the Applicable HCO Threshold

“Full applicable LTCH PPS payment” refers to the standard Federal rate (including any SSO adjustment, if applicable) or the site neutral payment rate, based on the LTCH case. “Applicable HCO threshold” refers to the HCO threshold determined from the standard Federal rate fixed-loss amount or the site neutral fixed-loss amount based on the LTCH case.

IF...	THEN...	EXAMPLE...
<p>The patient qualifies for the full applicable LTCH PPS payment and uses all regular benefit days for a stay before exceeding the applicable HCO threshold.</p>	<p>The LTCH gets only the full LTCH PPS payment (and does not get an HCO payment). The patient becomes liable for costs incurred the day after the case exceeds the applicable HCO threshold.</p>	<p>An LTCH admits a standard Federal rate patient with 36 remaining benefit days grouped to an MS-LTC-DRG with an ALOS of 30 days. The patient’s cost of care exceeds the standard Federal rate HCO threshold on day 45. Because the patient exhausted all benefit days before reaching the HCO threshold, the case is not eligible for an HCO payment. The patient is not liable for covered costs from days 37 through 45. They are liable for day 46 through discharge.</p>

If the patient’s benefits exhaust during the LTCH stay, determine:

- The day of the stay the cost of the case reaches the applicable HCO threshold (use charges per day and the CCR)
- The number of benefit days the patient has available

To calculate the HCO, use the costs for the days after the cost of the case reaches the applicable HCO threshold the patient has benefit days available. If the patient remains under care after benefits exhaust, the patient is liable for the costs of those remaining days.

Any changes to HCO payments under the LTCH PPS outlier reconciliation policy do not retroactively affect a patient’s lifetime reserve days or coverage status, benefits, and payments under Medigap or Medicaid.

HCO Fixed-Loss Amounts

Beginning October 1, 2015, under the new dual-rate LTCH PPS payment structure, CMS sets two HCO fixed-loss amounts: one for standard Federal rate payments and one for site neutral rate payments. The fixed-loss amount for cases based on the Federal rate is set at an amount that allows the projected total HCO payments in a given year to equal 7.975 percent of the total LTCH PPS standard Federal rate payments estimated for that year (the full MS-LTC-DRG payments or the adjusted SSO amount plus HCO payments). Before October 1, 2017, the fixed-loss amount for Federal payment rate cases was set so the estimated projected total HCO payments in a given year were equal to 8.0 percent of the total LTCH PPS standard Federal rate payments estimated for that year. For FYs 2016–2020, the site neutral cases fixed-loss amount is set to the same amount as the IPPS fixed-loss amount.

Medicare estimates the cost of each case using CCRs from the Provider Specific File (PSF). Use the applicable statewide average CCR when LTCHs' CCRs in the PSF are unavailable. MACs estimate the cost of a case by multiplying Medicare-covered charges by the LTCH's overall CCR, based on the most recently settled or tentatively settled cost report. These CCR revisions or determinations may also apply:

- CMS may direct MACs to use an alternate CCR that more accurately reflects recent substantial increases or decreases in a hospital's charges
- LTCHs may request their MAC(s) use a higher or lower CCR based on substantial evidence, when their CMS Regional Office approves it
- MACs annually assign the statewide average CCR to LTCHs with CCRs above the maximum ceiling
- MACs use the LTCH's actual CCR rather than the statewide average LTCH's CCR with CCRs below the minimum floor
- MACs may use the statewide average CCR when the LTCH CCR is undetermined (for example, before a new LTCH submits its first Medicare cost report or when data is unavailable to calculate a CCR because it is missing or incorrect)

The LTCH PPS outlier policy allows reconciling HCO payments at cost report settlement and accounts for differences between the estimated CCR and the actual CCR for the period when the discharge occurs.

Interrupted Stay

An interrupted stay happens when a patient discharges from an LTCH and re-admits to the same LTCH for further medical treatment. For example, an LTCH patient may be discharged for treatment and services not available in the LTCH.

There are two types of interrupted stays: 3-day or less, and greater than 3-day.

The day count of the interruption begins on the day of discharge; the first day the patient is away from the LTCH at midnight.

Three-Day or Less Interruption

Example:

If a patient discharges from an LTCH on September 2, the 3-day or less interrupted stay policy governs payment if the patient re-admits to the same LTCH on September 2, 3, or 4.

For discharges and re-admissions to the same LTCH within 3 days, the patient may:

- Get outpatient or inpatient tests, treatment, or care at an inpatient acute care hospital, Inpatient Rehabilitation Facility (IRF), or Skilled Nursing Facility (SNF)/Swing Bed
 - Any outpatient or inpatient care during the interruption is part of a single episode of LTCH care and bundled into the LTCH payment.

- If the patient gets tests or procedures during the 3-day interruption and the LTCH makes payment to the provider under arrangements, the total day count for the patient includes all days of the interruption.
- Have an intervening patient stay at home for up to 3 days with no tests, treatment, or care
 - If the patient does not get any care during the 3-day interruption, the LTCH cannot include the days away in the total LOS.
 - However, if care is delivered on any day during the interruption that the LTCH pays for “under arrangements,” all the days of the interruption are included in the LOS for that beneficiary stay.

Greater than 3-Day Interruption

Example:

If a patient discharges from an LTCH on September 2, the greater than 3-day interrupted stay policy governs payment if the patient re-admits to the same LTCH between September 5 and the applicable provider’s fixed period threshold.

For a greater than 3-day interruption, the patient must discharge from the LTCH, admit directly to an inpatient acute care hospital, IRF, or SNF/swing bed and return to the original LTCH within the applicable fixed-day period.

Facility Discharged to	Interrupted Stay Fixed Period
Inpatient acute care hospital	Between 4 and 9 consecutive days
IRF	Between 4 and 27 consecutive days
SNF/swing bed	Between 4 and 45 consecutive days

Medicare treats an interrupted stay episode as one discharge for payment and makes only one LTCH PPS payment. An interrupted stay is eligible for an HCO payment.

Medicare makes a separate payment for the intervening inpatient stay at the acute care hospital, IRF, or SNF/swing bed.

Not an Interrupted Stay

Examples:

- The patient’s stay at the receiving facility (acute care inpatient hospital, IRF, or SNF/swing bed) exceeds the fixed-day period.
- The patient discharges to a type of facility other than an acute care inpatient hospital, an IRF, or SNF/swing bed.
- The patient discharges to more than one facility or goes home between LTCH stays.

If a stay disruption does not meet the definition for an interrupted stay, the original discharge ends the patient's first stay. If the patient re-admits to the LTCH, the second admission begins a new stay. The LTCH gets two LTCH PPS payments (full MS-DRG payment or adjusted SSO payment, as applicable) for two patient stays: one payment for the first stay and a separate payment for the stay after LTCH re-admission.

Billing Requirements for Interrupted Stay

- The "from" date is the original date of admission.
- The "through" date is the final date of discharge.
- Report payable days in the Covered Days field (value code 80).
- Report interrupted days in the Non-Covered Days field (value code 81).
- Occurrence span code (OSC) 74 with the dates the patient was absent at midnight (interruptions of more than one day).
- OSC "from" date is the date of initial discharge from the LTCH.
- OSC "through" date is the last date the patient is not present at the LTCH at midnight.
- Do not change the principal diagnosis upon re-admission to the LTCH. If the patient has other medical conditions present on their return, report additional diagnosis codes on the claim.
- Use revenue code 018X to show the number of interruption days.

A new payment adjustment policy applies for cost reporting periods beginning on or after October 1, 2019. If an LTCH's discharge payment percentage for a cost reporting period is not at least 50 percent, this payment adjustment policy applies after Medicare calculates the percentage and notifies the LTCH. For cost reporting periods subject to this adjustment, the payment for all discharges consists of:

- An amount equivalent to the hospital IPPS
- If applicable, an additional payment for HCO cases based on the fixed-loss amount for an IPPS hospital in effect at the time of the LTCH discharge

The payment adjustment ends when the calculated discharge payment percentage for a cost reporting period is at least 50 percent. However, the LTCH could be subject to this adjustment again, if, after reinstatement, the discharge payment percentage falls below 50 percent.

An LTCH subject to the payment adjustment for a cost reporting period can get a special probationary reinstatement by having the payment adjustment delayed, if, for the period of at least 5 consecutive months of the 6 months immediately preceding the cost reporting period, the discharge payment percentage is calculated to be at least 50 percent. For any cost reporting period to which the payment adjustment would have applied but for a delay, the payment adjustment will be applied for all discharges in the cost reporting period if the discharge payment percentage is not at least 50 percent.

PAYMENT UPDATES

For more payment rate and other changes information, refer to the [FY 2020 LTCH PPS Final Rule and LTCH PPS Regulations and Notices](#).

LTCH QRP

Since FY 2014, Medicare subjects LTCHs that do not report quality data to a 2.0 percentage point reduction to the annual update of the LTCH PPS standard Federal payment rate.

Quality Reporting Measures Required for FY 2020 Annual Update

- NQF #0138—National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
- NQF #0139—National Health Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure
- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Short Stay)
- NQF #0431—Influenza Vaccination Coverage Among Healthcare Personnel
- NQF #1717—National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure
- NQF #0674—Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- NQF #2632—Functional Status Outcome Measure: Change in Mobility Among Long-Term Care Hospital (LTCH) Patients Requiring Ventilator Support
- NQF #2631—Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
- Medicare Spending Per Beneficiary (MSPB)-Post-Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
- NQF #3480—Discharge to Community-Post-Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
- Potentially Preventable 30-Day Post-Discharge Re-admission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
- Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
- Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay
- Ventilator Liberation Rate
- Transfer of Health Information to the Provider Post-Acute Care

For more information, refer to the [LTCH QRP](#).

RESOURCES

Table 1. LTCH PPS Resources

Resource	Website
Long-Term Care Hospital Prospective Payment System	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Long-Term Care Hospital Prospective Payment System Questions	ltchpps@cms.hhs.gov
Long-Term Care Hospital Quality Reporting Program	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting

Table 2. Hyperlink Table

Embedded Hyperlink	Complete URL
Coinsurance	https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance
FY 2020 LTCH PPS Final Rule	https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf
High-Cost Outlier	https://www.ecfr.gov/cgi-bin/text-idx?SID=e41124920411234f0c9a1897eac4225b&node=42:2.0.1.2.12&rgn=div5#se42.2.412_186
LTCH PPS Regulations and Notices	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices
LTCH QRP	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting
Short-Stay Outlier	https://www.ecfr.gov/cgi-bin/text-idx?SID=ecf71cf5748ac7f5deb40cd7ce656249&mc=true&node=se42.2.412_1529&rgn=div8

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