Centers for Medicare & Medicaid Services

LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM
HIGH COST OUTLIERS FACT SHEET

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What Is a High Cost Outlier?

A high cost outlier is an adjustment to the Federal payment rate for Long-Term Care Hospital (LTCH) stays with unusually high costs that exceed the typical cost for a Long-Term Care-Diagnosis Related Group (LTC-DRG). This adjustment strongly improves the accuracy of the Long-Term Care Hospital Prospective Payment System (LTCH PPS) in determining patient and hospital resource costs. High cost outlier payments reduce the LTCH's financial losses that result from treating patients who require more costly care. Additionally, the outlier policy reduces the incentives to underserve high cost patients. As a result of the additional payment, the LTCH's loss is limited to the fixed-loss amount and the percentage of costs above the marginal cost factor.

What Type of Cases Result in a High Cost Outlier Payment?

A case can result in a high cost outlier payment if the cost of the patient's stay is extraordinarily high when compared to the costs of most cases grouped to the same LTC-DRG.

Background	*What Are Long-Term Care-Diagnosis Related Groups?*
Under the Medicare system, Long-Term Care Hospitals (LTCHs) generally treat patients who require hospital-level care for an average of greater than 25 days. The Balanced Budget Refinement Act of 1999 (BBRA) mandated a new discharge-based prospective payment system for LTCHs. The new payment system, the Long-Term Care Hospital Prospective Payment System (LTCH PPS), replaces the current cost-based system. Congress provided further requirements for the LTCH PPS in the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvements and Protection Act of 2000 (BIPA).	The LTCH PPS uses Long-Term Care-Diagnosis Related Groups (LTC-DRGs) as a patient classification system. Each patient stay is grouped into an LTC-DRG based on diagnoses (including secondary diagnoses), procedures performed, age, gender, and discharge status. Each LTC-DRG has a pre-determined Average Length of Stay (ALOS), or the typical Length of Stay (LOS) for a patient classified to the LTC-DRG. Under the LTCH PPS, an LTCH receives payment for each Medicare patient, based on the LTC-DRG to which that patient's stay is grouped. This grouping reflects the typical resources used for treating such a patient. Cases assigned to an LTC-DRG are paid according to the Federal payment rate, including adjustments. One type of case-level adjustment is a high cost outlier.

How Does a Case Qualify for a High Cost Outlier Payment?

A case qualifies for a high cost outlier payment if the estimated cost of the case exceeds the high cost outlier threshold.

What Is the High Cost Outlier Threshold?

The high cost outlier threshold equals the LTCH PPS Federal payment for the case (either the applicable short-stay outlier or full LTC-DRG payment) plus the fixed-loss amount (see Calculation 1). The fixed-loss amount for the 2005 Rate Year is $17,864 (effective July 1, 2004).

How Are High Cost Outliers Paid?

High cost outlier payments are made in addition to the applicable short-stay outlier or full LTC-DRG payment established for the case. A high cost outlier payment is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

For each LTCH PPS Rate Year, the Centers for Medicare & Medicaid Services (CMS) establishes a fixed-loss amount so that the total high cost outlier payments in a given year are projected to be equal to 8 percent of the total LTCH PPS payments estimated for that year (i.e., the applicable short-stay outlier or full LTC-DRG payments plus high cost outlier payments).

How Is the Estimated Cost of the Case Determined?

The estimated cost of the case is determined by multiplying the Medicare covered charges for the case by the LTCH's overall Cost-to-Charge Ratio (CCR). Please refer to the calculation examples on this page to determine Medicare covered charges when a patient's benefits expire during the LTCH stay.

How Are High Cost Outlier Payments Calculated?

To calculate a high cost outlier payment, first determine the estimated cost of the case and the high cost outlier threshold. Next, compare the estimated cost of the case and the high cost outlier threshold to determine if the case qualifies for a high cost outlier payment (i.e., the cost of the case exceeds the high cost outlier threshold). If the case qualifies for a high cost outlier payment, the cost of the case and the high cost outlier threshold are then used to calculate the amount of the high cost outlier payment. The information shown below is an example of a high cost outlier payment calculation:

Data Used In The Following Example Payment Calculation

Full LTC-DRG Payment For LTC-DRG 113	$51,919.64
Fixed-Loss Amount (effective July 1, 2004)	$17,864
Overall Hospital Cost-to-Charge Ratio (CCR)	0.8114

Calculation 1: High Cost Outlier Threshold Calculation

LTC-DRG Payment + Fixed-Loss Amount

$51,919.64	Full LTC-DRG Payment For LTC-DRG 113
+ $17,864	Fixed-Loss Amount
$69,783.64	**High Cost Outlier Threshold**

Calculation 2: Estimated Cost of Case Calculation

Medicare Covered Charges x Overall Hospital CCR

$187,895.14	Medicare Covered Charges
x 0.8114	Overall Hospital CCR
$152,458.12	**Estimated Cost of Case**

For a high cost outlier, the Medicare covered charges are the Medicare allowable charges incurred during the days of the stay that the patient has a Medicare benefit day (either regular, coinsurance, and/or lifetime reserve) available, not the charges related to the LOS for the episode of care.

Calculation 3: High Cost Outlier Payment Calculation

80% x (Estimated Cost of Case - High Cost Outlier Threshold)

$152,458.12	Estimated Cost of Case (See Calc. 2)
- $69,783.64	High Cost Outlier Threshold (See Calc. 1)
$82,674.48	
x 0.80	Decimal Representation of 80%
$66,139.58	**High Cost Outlier Payment**

In the example above, the case would be paid $118,059.22 (the full LTC-DRG payment of $51,919.64 plus the high cost outlier payment of $66,139.58). In the first four years of the transition to the LTCH PPS, an offset to the final payment for each case is made to maintain budget neutrality.

How Is the Fixed-Loss Amount Determined?

CMS determines the fixed-loss amount using the best available MedPAR claims data and cost report data. CMS computed CCRs for determining the fixed-loss amount for the 2005 LTCH PPS Rate Year based on the latest

available cost report data in the Healthcare Cost Reporting Information System (HCRIS) and corresponding MedPAR claims data from Fiscal Years (FYs) 1999, 2000, 2001, and 2002. The fixed-loss amount that is used in the calculation for the high cost outlier payment formula results in outlier payments that are equal to 8 percent of projected total LTCH PPS payments (i.e., the applicable short-stay outlier or full LTC-DRG payments plus high cost outlier payments). CMS recalculates the fixed-loss amount annually.

How Is the Cost-to-Charge Ratio (CCR) Calculated?

Under the Final Rule published on August 30, 2002, the Fiscal Intermediary calculated the LTCH's CCR from the latest settled cost report or from the applicable statewide average (if the cost report was not available, or if the value was outside of the applicable range). However, the June 9, 2003 Outlier Final Rule made changes to the CCR policy. These CCR policy changes took effect on August 8, 2003, and October 1, 2003, respectively.

CCR Changes Effective For Discharges On Or After August 8, 2003

- **CCR Revisions Requested by CMS:** Fiscal Intermediaries may use an alternative CCR, as directed by CMS, which more accurately reflects recent substantial increases or decreases in a hospital's charges.
- **CCR Revisions Requested by the LTCH:** Upon approval by the respective Regional Office, LTCHs may request that Fiscal Intermediaries use a different (higher or lower) CCR. This request must be based on substantial evidence.
- **CCR Revisions for LTCHs with CCRs Below the Minimum Threshold (Floor):** Fiscal Intermediaries will stop assigning the statewide average CCR to LTCHs with CCRs below the minimum threshold (floor). In those cases, Fiscal Intermediaries will use the LTCH's actual CCR. LTCHs with CCRs above the upper threshold (ceiling) will continue to be assigned the statewide average CCR.

CCR Change Effective For Discharges On Or After October 1, 2003

- **CCR Applied at the Time of Claim Processing:** Fiscal Intermediaries will calculate an LTCH's CCR from the latest settled or tentatively settled cost report (whichever is later).

In addition to the above-mentioned changes to the CCR policy, effective for discharges on or after August 8, 2003, the Outlier Final Rule, published on June 9, 2003, allows for reconciliation of high cost outlier (and short-stay outlier) payments upon cost report settlement. This reconciliation accounts for differences between the estimated CCR and the actual CCR for the period during which the discharge occurs.

LTCH PPS Final Rules

CMS published four Final Rules affecting Medicare payments to LTCHs on the following dates:

August 30, 2002 - the first LTCH PPS Final Rule was published, formalizing the policies and procedures for the new LTCH PPS.

June 6, 2003 - the first update of the LTCH PPS Final Rule was published, changing the update cycle for future LTCH PPS updates, and revising several payment rates for the LTCH PPS, including the fixed-loss amount.

June 9, 2003 - the Outlier Final Rule was published, affecting payment calculations for outlier cases. This Final Rule provided several changes to the application of the Cost-to-Charge Ratio (CCR), as well as changes to outlier payment reconciliation policies.

May 7, 2004 - the FY 2005 Final Rule was published, increasing the Medicare payment rates for LTCHs by 3.1% for FY 2005 starting on July 1, 2004. The Final Rule also further expands the existing interrupted stay policy, finalizes the requirements for a satellite or remote location to qualify as an LTCH, and changes the ALOS calculation for LTCH status.

Who Determines If a High Cost Outlier Payment Applies?

Upon receipt of the claim, the Fiscal Intermediary will determine high cost outlier payments using the PRICER software. The Fiscal Intermediary will also determine if enough benefit days existed for each medically necessary day in the outlier period. If the patient had enough benefit days, the Fiscal Intermediary will process the claim as usual, with no other action needed from the LTCH. If the patient did not have enough benefit days, the Fiscal Intermediary will return the claim, with the appropriate high cost outlier threshold amount indicated, to the LTCH for correction.

Can a Case Qualify for Both Short-Stay Outlier and High Cost Outlier Payments?

If the estimated cost of the short-stay outlier case exceeds the high cost outlier threshold, the short-stay outlier case would also qualify as a high cost outlier case. For short-stay outlier cases, the outlier threshold is determined by adding the fixed-loss amount to the applicable short-stay outlier payment for the LTC-DRG (not the full LTC-DRG payment). Please see the Short-Stay Outliers Fact Sheet for more information on short-stay outliers.

What if the Patient's Benefits Expire During the LTCH Stay?

Under the LTCH PPS, Medicare will only make a high cost outlier payment for days that the beneficiary has Medicare coverage (either regular, coinsurance, or lifetime reserve days) for the period (or portion of the stay) beyond the high cost outlier threshold (see Calculation 1). Medicare will only make high cost outlier payments for covered costs associated with medically necessary days for which the patient has a benefit day available.

Example:

If…	*Then…*	*Example*
A patient's benefits are exhausted before qualifying for a full LTC-DRG payment and the cost of covered care exceeds the high cost outlier threshold for the applicable short-stay outlier payment…	*The LTCH receives a high cost outlier payment in addition to the short-stay outlier payment for the covered medically necessary benefit days.*	*A patient is admitted to the LTCH with 5 remaining benefit days, and is grouped to an LTC-DRG with an ALOS of 30 days. The patient does not have enough regular benefit days to trigger a full LTC-DRG payment (5/6 of the ALOS for the LTC-DRG) for this stay. The lack of benefit days qualifies the case for a short-stay outlier payment. The facility's cost for providing covered services during the 5 benefit days exceeds the high cost outlier threshold. Therefore, the case also qualifies for a high cost outlier payment for all costs above the high cost outlier threshold for Days 1-5. The patient is liable for Day 6 through discharge.*
If…	***Then…***	***Example***
A patient's benefits are exhausted after qualifying for a full LTC-DRG payment and the cost of covered care exceeds the high cost outlier threshold for the applicable full LTC-DRG payment…	*The LTCH receives a high cost outlier payment in addition to the full LTC-DRG payment for the covered medically necessary benefit days.*	*A patient is admitted to the LTCH with 36 remaining benefit days, and is grouped to an LTC-DRG with an ALOS of 30 days. By Day 33, the patient's cost of care has exceeded the high cost outlier threshold. The case qualifies for both a full LTC-DRG payment and a high cost outlier payment for all covered costs (for which there is a benefit day available) above the high cost outlier threshold. The patient is liable for Day 37 through discharge.*
But. . .		
If…	***Then…***	***Example***
A patient qualifies for a full LTC-DRG and uses all of his or her regular benefit days for a stay before the high cost outlier threshold is exceeded…	*The LTCH receives only a full LTC-DRG payment. A high cost outlier payment is not made by Medicare under the LTCH PPS.* *In addition, the patient is not liable for the costs that are incurred until the day after the high cost outlier threshold for the LTC-DRG is exceeded.*	*A patient is admitted to the LTCH with 36 remaining benefit days, and is grouped to an LTC-DRG with an ALOS of 30 days. The patient's cost of care does not exceed the high cost outlier threshold until Day 45. Since the patient has exhausted all of his or her benefit days before reaching the high cost outlier threshold, the case is not eligible for a high cost outlier payment. The patient is not liable for covered costs from Days 37-45. However, the patient is liable for Day 46 through discharge. This case receives only the full LTC-DRG payment because it does not qualify for a high cost outlier payment under the LTCH PPS.*

Medicare provides 90 covered benefit days for an episode of care under the inpatient hospital benefit. In addition, each patient has 60 lifetime reserve days. These lifetime reserve days may be used to cover additional non-covered days of an episode of care that exceeds 90 days.

If the Patient's Benefits Expire During the LTCH Stay, How Is Any Applicable High Cost Outlier Payment Calculated?

If the patient's benefits expire during the LTCH stay, first determine on what day of the stay the cost of the case reaches the high cost outlier threshold (using charges per day and the CCR). Then, determine the number of benefit days the beneficiary has available. Only the costs for the days after the cost of the case reaches the high cost outlier threshold amount for which the patient has benefit days available are used in the calculation of a high cost outlier payment. If the patient remains under care following the expiration of benefits, the patient is liable for the costs of those remaining days.

How Will the Reconciliation of High Cost Outlier Payments Affect a Beneficiary's Lifetime Reserve Days and Eligibility for Coverage Under Medigap and Medicaid Programs?

Because the changes discussed in the June 9, 2003 Outlier Final Rule address the accuracy of outlier payments rather than coverage or liability, any changes to a LTCH's outlier payment made as a result of reconciliation will not retroactively affect a beneficiary's lifetime reserve days or coverage status under Medigap or Medicaid. Specifically, no retroactive adjustments will be made to determine the day that a beneficiary's stay moves to high cost outlier status. Therefore, no retroactive adjustments will be made to lifetime reserve days used or available. Similarly, no retroactive adjustments will be made to beneficiary benefits and payments under Medigap and Medicaid.

Where Can I Find More Information about the LTCH PPS?

The following online references provide more information about the LTCH PPS:

- The Medicare Learning Network LTCH PPS Web Page

  www.cms.hhs.gov/medlearn/ltchpps.asp

  The Medicare Learning Network features CMS provider education materials for the LTCH PPS, including the *CMS Long-Term Care Hospital Prospective Payment System Training Guide*.

- Long-Term Care Hospital Web Page

  www.cms.hhs.gov/providers/longterm/default.asp

  The Long-Term Care Hospital Web Page provides the Final Rules and additional LTCH PPS-related documents, including a Frequently Asked Questions (FAQs) List. The website also provides instructions on joining the LTCH PPS mailing list, which provides the latest LTCH PPS news and updates.

- LTCH PPS Press Release updating LTCH Payment System for Rate Year 2005

  www.cms.hhs.gov/media/press/release.asp?Counter=1028

  The press release summarizes how Medicare is updating the format and data of the LTCH PPS system for Rate Year 2005. These changes were also published in the Federal Register on May 7, 2004.

- Final Rule on Annual Payment Rate Updates and Policy Changes

  www.cms.hhs.gov/providers/longterm/cms-1263-f.pdf

  The Final Rule provides a more in-depth look at the changes for Rate Year 2005.

- Federal Register Notice for LTCH PPS FY 2005 Proposed Rule (CMS-1428-P)

  www.cms.hhs.gov/providers/longterm/frnotices.asp

  The Proposed Rule contains the proposed LTC-DRGs, relative weights, ALOS, and other proposed Inpatient Prospective Payment System (IPPS)-excluded hospital policy changes that would be effective October 1, 2004, under the LTCH PPS.

Questions about high cost outliers and the LTCH PPS can be emailed to ltchpps@cms.hhs.gov.

Where Can I Find More Information about ICD-9-CM Coding?

The LTCH PPS Final Rule emphasized that proper coding is essential for correct diagnosis and procedure reporting. The following online references provide ICD-9-CM coding guidance:

- The ICD-9-CM Official Guidelines for Coding and Reporting

  www.cdc.gov/nchs/data/icd9/icdguide.pdf

  The LTCH PPS Final Rule stated that the *ICD-9-CM Official Guidelines for Coding and Reporting* is essential reading for understanding how to report the proper diagnosis and procedure codes that are used in determining the LTC-DRG payment amounts.

- Updates to the ICD-9-CM Diagnosis and Procedure Codes

  www.cms.hhs.gov/paymentsystems/icd9/default.asp

  This website identifies the activities (including public meeting schedules and agendas) of the ICD-9-CM Coordination and Maintenance Committee charged with maintaining and updating the ICD-9-CM coding system.