CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 698

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: OCTOBER 7, 2005

Change Request 4065

SUBJECT: The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Year 2006 for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

I. SUMMARY OF CHANGES: This instruction provides updated information for determining additional payment amounts for Inpatient Rehabilitation Facilities (IRF) with low-income patients(LIPs).

NEW/REVISED MATERIAL

EFFECTIVE DATE: October 1, 2005

IMPLEMENTATION DATE: November 7, 2005

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/Table of Contents
N	3/140/2.4.3/LIP Adjustment: The Supplemental Security Income (SSI) Medicare Beneficiary Data for IRFs Paid Under the PPS

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 698	Date: October 7, 2005	Change Request 4065

SUBJECT: The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Year 2006 for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

I. GENERAL INFORMATION

This instruction provides updated information for determining additional payment amounts for an IRF with low-income patients.

A. Background: The SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their adjustment for low income patients (LIP) for a cost reporting period that begins subsequent to that specified FY. The file will be updated annually (usually each October/November) More specifically, this instruction provides updated data for determining additional payment amounts for the IRFs with low-income patients. The SSI/Medicare beneficiary data for the IRF PPS is available to fiscal intermediaries (FIs) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs shall use this information to update their provider specific file. The file is located at the following CMS Web site address: http://www.cms.hhs.gov/providers/irfpps/ssidata_ratios.asp

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. Since the disproportionate share percentage is based on a facility's cost reporting period, FIs make a final determination of the amount of this percentage to compute the final LIP adjustment at the year-end settlement of the facility's cost report. The final LIP adjustment is used to retrospectively adjust the initial PPS payment amount.

B. Policy: Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare disproportionate share hospital (DSH) percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation), is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. For the second computation, the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate low-income patient adjustment for each IRF.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4065.1	FIs shall update their IRF PPS provider specific files by October 1, 2005.	X								
4065.2	FIs shall make a final determination of an IRF's eligibility for any low-income patient adjustment at the year-end settlement of the IRF's cost report.	X								
4065.3	FIs shall make a final determination of an IRF's amount of any low-income patient adjustment at the year-end settlement of the hospital's cost report.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4065.4	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: IRF PPS Provider Specific Files

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2005 **Implementation Date:** November 7, 2005 **Pre-Implementation Contact(s):** August Nemec 410-786-0612 **Post-Implementation Contact(s):** August Nemec 410-786-0612	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 698, 10-07-05)

140.2.4.3 – Low Income Percentage (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment system (PPS)

(Rev. 698, Issued: 10-07-05, Effective: 10-01-05, Implementation: 11-07-05)

The LIP adjustment accounts for differences in costs among IRFs associated with differences in the proportion of low-income patients treated. The LIP adjustment is calculated as (1 + disproportionate share hospital (DSH) patient percentage) raised to a power specified in the most recent IRF PPS final rule published in the Federal Register. To compute the DSH patient percentage the following formula is used:

$$DSH = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

This instruction provides the data for determining additional payment amounts for IRFs with low-income patients. An SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their LIP adjustment for a cost reporting period that begins subsequent to the FY specified by the data file. As appropriate a file will be updated annually (usually each October/November).
The SSI/Medicare beneficiary data for IRF PPS is available to fiscal intermediaries (FIs) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs will use this information to update their provider specific file. The files in the column labeled "Filename" specified below are located at the following CMS Web site address:

Cost Report Periods Beginning in:	*Filename*	*Mainframe File*
FY 2002 (1/1/02-9/30/02) Settled	*http://www.cms.hhs.gov/providers/irfpps/ssiratio02.zip*	*K143.@BFN2699.REHAB02.SSI.FILE1*
FY 2003 (10/1/02-9/30/03) Settled	*http://www.cms.hhs.gov/providers/irfpps/ssiratio03.zip*	*K143.@BFN2699.REHAB03.SSI.FILE*
FY 2004 (10/1/03-9/30/04) Settled	*http://www.cms.hhs.gov/providers/irfpps/ssiratio04.zip*	*ML00.@BFN2699.REHAB04.FILE*
FY 2005 (10/1/04-9/30/05) Interim	*http://www.cms.hhs.gov/providers/irfpps/ssiratio04.zip*	*ML00.@BFN2699.REHAB04.FILE*
FY 2006 (10/1/05-9/30/06) Interim	*http://www.cms.hhs.gov/providers/irfpps/ssiratio04.zip*	*ML00.@BFN2699.REHAB04.FILE*

http://www.cms.hhs.gov/providers/irfpps/ssidata_ratios.asp

The table below contains the files for calculating the SSI ratio for the associated fiscal year. Note that the last three years share the same data files until the cost reporting period is settled for the most recent fiscal year.

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. FIs make a determination of the amount of this percentage to compute the final LIP adjustment which allows the year-end settlement of a facility's cost report. When the FI settles a cost report for a specific fiscal year, that settled cost report will determine the final SSI ratio that is associated with that cost report. The FI uses the most recently settled SSI ratio to settle the current cost report. Once the final SSI ratio is determined for the actual fiscal year the cost report corresponds to, a retrospective adjustment may be made to account for the difference between the actual lip adjustment amount and the initial PPS lip adjustment payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

PM - A-99-62 (Excerpts referenced in PM A-01-131)

Background

Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare DSH percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation), is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. Second, a determination is made regarding the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate LIP adjustment for each IRF.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid

because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	*Description*	*Eligible Title XIX Day*
General Assistance Patient Days	*Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan*	*No*
Other State-Only Health Program Patient Days	*Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan*	*No*
Charity Care Patient Days	*Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.*	*No*
Actual 1902(r)(2) and 1931(b) Days	*Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.*	*Yes*
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	*Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.*	*Yes*
Separate CHIP Days	*Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.*	*No.*
1915(c) Eligible Patient (the "217" group) Days	*Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.*	*Yes*
Retroactive Eligible Days	*Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.*	*Yes*
Medicaid Managed Care Organization Days	*Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility*	*Yes*
Medicaid DSH Days	*Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible.*	*No*

Type of Day	*Description*	*Eligible Title XIX Day*
	Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.	