CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 392 **Date: DECEMBER 10, 2004**

CHANGE REQUEST 3567

SUBJECT: The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Year 2003 for 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 a disproportionate share of low-income patients.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2004
IMPLEMENTATION DATE: January 10, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/140/140.2.4.1/LIP Adjustment: The Supplemental Security Income (SSI)
	Medicare Beneficiary Data for IRFs Paid Under PPS

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 392	Date: December 10, 2004	Change Request 3567

SUBJECT: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2003 for Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

I. GENERAL INFORMATION

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 Inpatient Rehabilitation Facilities (IRF) with a disproportionate share of low-income patients. 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 file is located at the following CMS Web site address:

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

The table below contains the files for calculating the SSI ratio for each fiscal year. Please make note that the last 3 years share the same data files until the cost reporting period is settled for the most recent fiscal year.

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) Interim	http://www.cms.hhs.gov/providers/irfpps/ssiratio03.zip	K143.@BFN2699.REHAB03.SSI.FILE
FY 2005 (10/1/04-9/30/05) Interim	http://www.cms.hhs.gov/providers/irfpps/ssiratio03.zip	K143.@BFN2699.REHAB03.SSI.FILE

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs with cost reporting periods beginning on or after the first day of the cost reporting period, and before the first day of the next 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 low-income patient (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. The SSI data is updated on an annual basis and these data are one of the components used to determine an appropriate low-income patient adjustment for each IRF.

C. Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3567.1	Fiscal Intermediaries (FIs) shall update their IRF PPS provider specific files by October 1, 2004.	X								
3567.2	FIs shall make a final determination of an IRF's eligibility for any disproportionate share adjustment at the year-end settlement of the IRF's cost report.	X								
3567.3	FIs shall make a final determination of an IRF's amount of any disproportionate share adjustment at the year-end settlement of the hospital's cost report.	X								

III. 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 File

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2004 **Implementation Date:** January 10, 2005 **Pre-Implementation Contact(s):** August Nemec, (410) 786-0612, email: anemec@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

140.2.4.1 -- LIP Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for *IRFs* Paid Under the PPS

(Rev. 392, Issued: 12-10-04, Effective: 10-01-04, Implementation: 01-10-05)

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 Inpatient Rehabilitation Facilities (IRF) with a disproportionate share of low-income patients. 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 file is located at the following CMS Web site address:

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

The table below contains the files for calculating the SSI ratio for each fiscal year. Please make note that the last 3 years share the same data files until the cost reporting period is settled for the most recent fiscal year.

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) Interim	*http://www.cms.hhs.gov/providers/irfpps/ssiratio03.zip*	*K143.@BFN2699.REHAB03.SSI.FILE*
FY 2005 (10/1/04-9/30/05) Interim	*http://www.cms.hhs.gov/providers/irfpps/ssiratio03.zip*	*K143.@BFN2699.REHAB03.SSI.FILE*

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs with cost reporting periods beginning on or after the first day of the cost reporting period, and before the first day of the next 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 low-income patient (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.

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 §1886(d)(5)(F) of the Act, the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes 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).) This number is divided by the total number of patient days for that same period.

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	No

Type of Day	Description	Eligible Title XIX Day
	Medicaid-eligible. 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.	