CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 39 | **Date: DECEMBER 8, 2003**

CHANGE REQUEST 2978

I. SUMMARY OF CHANGES: This Change Request (CR) provides updated data for determining additional payment amounts for the low-income patient adjustment applicable for facilities subject to the IRF PPS.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2003
***IMPLEMENTATION DATE: January 5, 2004**

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/140.2.4.1/ LIP Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2002 for IRFs Paid Under the PPS

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

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

Business Requirements

Pub. 100-04	Transmittal: 39	Date: December 8, 2003	Change Request 2978

I. GENERAL INFORMATION

A. Background: This Change Request (CR) provides updated data for determining additional payment amounts for the low-income patient adjustment applicable for facilities subject to the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).

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: Intermediaries shall inform affected provider communities by posting relevant portions of this CR on their Web sites within two weeks of the issuance date of this CR. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about "The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2002 for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) " is available on your Web site.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2978.1	Fiscal Intermediaries (FIs) shall update their IRF PPS provider specific files 2 weeks after the issuance date of this CR.	FIs
2978.2	FIs shall make a final determination of an IRF’s amount of low-income adjustment at the year-end settlement of the facility’s cost report.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A
B. Design Considerations: N/A
C. Interfaces: Provider Specific File
D. Contractor Financial Reporting /Workload Impact: N/A
E. Dependencies: N/A
F. Testing Considerations: N/A

IV. OTHER CHANGES

SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2003 **Implementation Date: January 5, 2004** **Pre-Implementation Contact(s): August Nemec at (410) 786-0612 or ANemec@cms.hhs.gov** **Post-Implementation Contact(s): Regional Office**	**These instructions should be implemented within your current operating budget.**

140.2.4.1 -- LIP Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2002 for IRFs Paid Under the PPS

(Rev. 39, 12-08-03)

The SSI/Medicare beneficiary data for the IRF PPS is available to FIs electronically. This data is used to identify the disproportionate share percentage for all IRFs in the FI provider specific file so that FIs use the most current data in paying bills. The data 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 available on the CMS Mainframe under the file name:

K143.@BFN2699.REHAB02.SSI.FILE1

The SSI file is also available on the Internet at the following Web address: www.cms.hhs.gov/medicare/irfpps.asp

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 *October 1, 2003 and before October 1, 2004*. 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. *Specifically, the FY 2002 SSI data is used for settlement purposes for facilities with cost reporting periods beginning on or after January 1, 2002 and before October 1, 2003.* 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 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.	No