Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

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Note: This article was revised on October 18, 2017, to reflect a revised CR10273 issued on October 17. The CR was revised to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment to the CR. The article was updated accordingly. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by short term acute care and long-term care hospitals (LTCHs).

PROVIDER ACTION NEEDED

Change Request (CR) 10273 implements policy changes for the Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS). Failure to adhere to these new policies could affect payment of Medicare claims.

BACKGROUND

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a PPS for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.
IPPS FY 2018 Update

The following policy changes for FY 2018 were displayed in the Federal Register on August 2, 2017, with a publication date of August 14, 2017. All items covered in CR10273 are effective for hospital discharges occurring on or after October 1, 2017, through September 30, 2018, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2017, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2017, through September 30, 2018.

Files for download listed throughout the CR are available on the Centers for Medicare & Medicaid Services (CMS) website. The key links are:


Alternatively, the files on the webpages listed above are also available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, “FY 2018 IPPS Final Rule Home Page” or the link titled “Acute Inpatient--Files for Download” (and select ‘Files for FY 2018 Final Rule and Correction Notice’).

IPPS FY 2018 Update

A. FY 2018 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2018 IPPS/LTCH PPS Final Rule, available on the FY 2018 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, high cost outlier (HCO) threshold, and cost-of-living adjustment (COLA) factors, refer to the MAC Implementation Files 1 available on the FY 2018 MAC Implementation Files webpage.

B. Medicare Severity - Diagnosis Release Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes
The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) MS-DRG Grouper, Version 35.0, software package effective for discharges on or after October 1, 2017. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 35.0 which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2017.

For discharges occurring on or after October 1, 2017, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2017, the MCE selects the proper internal code edit tables based on discharge date.

For the October update, CMS has:

- Reduced the number of MS-DRGs from 757 to 754 for FY 2018. CMS is not implementing any new MS-DRGs for FY 2018. In addition, CMS is deleting MS-DRGs 984, 985 and 986.

- Revised the title to MS-DRG 023 to Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator.

- Modified the titles for MS-DRGs 061, 062, and 063 to Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w MCC, CC and without CC/MCC, respectively, and retitled MS-DRG 069 to Transient Ischemia without Thrombolytic.

- Revised the titles for MS-DRGs 246 and 248 to state “arteries” instead of “vessels” to better reflect the I-10 terminology in the classification. The revised titles for MS-DRGs 246 and 248 are Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries or stents and Percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ arteries or stents, respectively.

- Modified the title for MS-DRGs 469 and 470 to Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement and Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC, respectively.

- Revised the titles for MS-DRGs 823, 824 and 825 to Lymphoma and Non-Acute Leukemia with Other Procedure with MCC, with CC and without CC/MCC, respectively.
• Revised the titles for MS-DRGs 829 and 830 to Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedure with CC/MCC and without CC/MCC, respectively.

C. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2018 have been evaluated against the general post-acute care transfer policy criteria using the FY 2016 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review, no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy; however MS-DRGs 987, 988 and 989 (Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis with major complication or comorbidity (MCC), with complication or comorbidity (CC), without CC/MCC, respectively) were added to the special payment policy list. See Table 5 of the FY 2018 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2018 Final Rule Tables webpage.

D. New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2018:

1. Name of Approved New Technology: Defitelio®
   - Maximum Add-on Payment: $75,900
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 or XW04392

2. Name of Approved New Technology: GORE IBE device system
   - Maximum Add-on Payment: $5,250
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC3EZ; 04VC4EZ; 04VD0EZ; 04VD3EZ or 04VD4EZ (CMS notes ICD-10-PCS procedure codes 04VC0FZ; 04VC3FZ; 04VC4FZ; 04VD0FZ; 04VD3FZ; and 04VD4FZ are no longer valid effective October 1, 2017)

3. Name of Approved New Technology: Idarucizumab
   - Maximum Add-on Payment: $1,750
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03331 or XW04331

4. Name of Approved New Technology: Vistogard™
• Maximum Add-on Payment: $40,130 (Note: The maximum payment has changed from FY 2018)

• Identify and make new technology add-on payments with any of the following ICD-10 clinical modification (ICD-10-CM) diagnosis codes T45.1x1A, T45.1x1D, T45.1x1S, T45.1x5A, T45.1x5D, or T45.1x5S in combination with (ICD-10-PCS procedure code XW0DX82)

The following items are eligible for new-technology add-on payments in FY 2018:

5. Name of Approved New Technology: ZINPLAVA™
   • Maximum Add-on Payment: $1,900
   • Identify and make new technology add-on payments with ICD-10-PCS procedure codes XW033A3 or XW043A3.

6. Name of Approved New Technology: Stelara®
   • Maximum Add-on Payment: $2,400
   • Identify and make new technology add-on payments with ICD-10-PCS procedure code XW033F3.

7. Name of Approved New Technology: EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
   • Maximum Add-on Payment: $6,110.23
   • Identify and make new technology add-on payments with ICD-10-PCS code X2RF032.

E. Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. CMS has updated the COLAs for FY 2018, and the COLAs for the qualifying counties in all of Alaska and in Hawaii is 1.25, except for the county of Hawaii which is 1.21. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2017, are available in the FY 2018 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2018 MAC Implementation Files webpage.

F. FY 2017 Wage Index Changes and Issues

1. Transitional Wage Indexes

Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and
Budget (OMB) using 2010 Census data.

For hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, CMS assigned a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years for FY 2015, 2016 and 2017. These hold harmless wage indexes have expired for FY 2018. MACs will ensure hospitals that were eligible for transitional wage indexes in FY 2017 no longer receive a transitional wage index for FY 2018.

2. Adoption of Federal Information Processing Standard (FIPS) County Codes

Core Based Statistical Areas (CBSAs) are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and FIPS codes. Historically, CMS has listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the hospital wage index. CMS has learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau’s most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For the purposes of crosswalking counties to CBSAs, in the FY 2018 IPPS/LTCH PPS final rule, CMS finalized that it would discontinue the use of SSA county codes and begin using only the FIPS county codes beginning in FY 2018.

Based on information included in the Census Bureau’s website, since 2010, the Census Bureau has made the following updates to the FIPS codes for counties or county equivalent entities:

- Petersburg Borough, AK (FIPS State County Code 02-195), CBSA 02, was created from part of former Petersburg Census Area (02-195) and part of Hoonah-Angoon Census Area (02-105). The CBSA code remains 02.
- The name of La Salle Parish, LA (FIPS State County Code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22-059). The CBSA code remains as 14.
- The name of Shannon County, SD (FIPS State County Code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46-102). The CBSA code remains as 43.

CMS adopted the implementation of these FIPS code updates, effective October 1, 2017, beginning with the FY 2018 wage indexes. A County to CBSA Crosswalk File is available on the FY 2018 Final Rule Data Files webpage.

Note: The county update changes listed above changed the county names. However, the CBSAs to which these counties map did not change from the prior counties. Therefore, there is no payment impact or change to hospitals in these counties; they continue to be considered rural for the hospital wage index under these changes.
3. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. The following is a list of hospitals that have waived LUGAR status for FY 2018: 010164, 070004, 070011, 140167, 250117, 390008, 390031, 390150 and 520102.

4. Section 505 Hospital (Out-Commuting Adjustment)

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the “outmigration adjustment, is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under § 412.103, or redesignated under section 1886(d)(8)(B) of the Act.

G. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals reclassified under the MGCRB

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes. Note, hospitals reclassified as rural under § 412.103 are not eligible for the capital Disproportionate Share Hospital (DSH) adjustment since these hospitals are considered rural under the capital PPS (see § 412.320(a)(1)).

Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and § 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under § 412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a Lugar hospital to keep its Lugar status if it was approved for an urban to rural reclassification under § 412.103. Effective April 21, 2016, hospitals nationwide that have an MGCRB reclassification or Lugar status during FY 2016 and subsequent years can simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or Lugar status.

H. Multicampus Hospitals with Inpatient Campuses in Different CBSAs

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital in the Provider Specific File (PSF), to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with
each campus’s geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF.

I. Updating the PSF for Wage Index, Reclassifications and Redesignations

MACs will update the PSF by following the steps, in order, in Attachment 1 of CR10273 to determine the appropriate wage index based on policies mentioned above.

J. Expiration of Medicare-Dependent, Small Rural Hospital (MDH) Program

The MDH program is currently effective through September 30, 2017, as provided by section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the Federal rate. (Note that, the SCH policy at § 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 will no longer be valid beginning October 1, 2017.

K. Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs)

For FY 2018, the HSP amount in the PSF for SCHs (and MDHs as applicable) will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

Note: The FY 2017 2 midnight rule one time prospective increase of 1.006 (as well as the removal of 0.998 2 midnight rule adjustment applied in 2014) are not applied to the HSP update for FY 2018.

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY2018

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through September 30, 2017, as provided by section 204 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010). The regulations implementing the hospital payment adjustment policy are at § 412.101.

In addition, CMS is implementing an adjustment parallel to the low-volume hospital payment
adjustment so that, for discharges occurring in FY 2018 and subsequent years, only the distance between Indian Health Service (IHS) or Tribal hospitals will be considered when assessing whether an IHS or Tribal hospital meets the mileage criterion under § 412.101(b)(2). Similarly, only the distance between non-IHS hospitals would be considered when assessing whether a non-IHS hospital meets the mileage criterion under § 412.101(b)(2). This parallel adjustment is implemented in 42 CFR 412.101(e).

For FY 2018, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2017, in order for the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2017 (through September 30, 2018). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2017 may continue to receive a low-volume hospital payment adjustment for FY 2018 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2018. As in previous years, such a hospital must send written verification that is received by its MAC no later than September 1, 2017, stating that it meets the mileage criterion applicable for FY 2018. For FY 2018, this written verification must also state, based upon the most recently submitted cost report, that the hospital meets the discharge criterion applicable for FY 2018 (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges). If a hospital’s request for low-volume hospital status for FY 2018 is received after September 1, 2017, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the 25-percent, low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2018 discharges, effective prospectively within 30 days of the date of the MAC’s low-volume hospital status determination. CMS notes that this process mirrors its established application process but is updated to ensure that providers currently receiving the low-volume hospital payment adjustment verify that they meet both the mileage criterion and the discharge criterion applicable for FY 2018 to continue receiving the adjustment for FY 2018.

The low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), Indirect Medical Education (IME) and outliers. For SCHs (and MDHs, when applicable), the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

M. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at www.qualitynet.org. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the list.

N. Hospital Acquired Condition Reduction Program (HAC)

Under the HAC Reduction Program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital’s discharges for the specified fiscal year.
A list of providers subject to the HAC Reduction Program for FY 2018 was not publicly available in the final rule because the review and correction process was not yet completed. MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

O. Hospital Value Based Purchasing (VBP)

For FY 2018, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2018. CMS expects to post the value-based incentive payment adjustment factors for FY 2018 in the near future in Table 16B of the FY 2018 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2018 IPPS Final Rule Tables webpage).

P. Hospital Readmissions Reduction Program

The readmissions payment adjustment factors for FY 2018 are in Table 15 of the FY 2018 IPPS/LTCH PPS final rule (which are available through the Internet on the FY 2018 IPPS Final Rule Tables webpage). Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2018 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2018, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

NOTE: Hospitals located in Maryland (for FY 2018) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15. Therefore, MACs shall follow the instructions in the second bullet above for the PSF for these hospitals.

Q. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of the aggregate amount available for uncompensated care payments based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care for FY 2018 is based on the average of three individual Factor 3s calculated using three sets of data. The first two sets of data consist of Medicaid days and Medicare SSI days, while the third consists of hospital uncompensated care costs from Worksheet S-10.

The Medicare DSH payment is reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH
payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment is applied in PRICER.

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2018 IPPS Final Rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2018. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition the estimated per discharge uncompensated care payment amount will be included as a Federal payment for SCHs to determine if a claim is paid under the hospital-specific rate or Federal rate (and for MDHs to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the Federal rate, when applicable). The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

For FY 2018, new hospitals with a CCN established after October 1, 2014 that are eligible for Medicare DSH will have their Factor 3 calculated at cost report settlement using uncompensated care costs reported on Line 30 of Worksheet S-10 as the numerator and a denominator of $25,199,302,174. Factor 3 is then applied to the total uncompensated care payment amount finalized in the FY 2018 IPPS Final Rule to determine the total amount to be paid to the hospital. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as new.

R. Recalled Devices

A hospital’s IPPS payment is reduced, for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list. There are no new MS-DRGs for FY 2018 subject to the policy for replaced devices offered without cost or with a credit.

CMS is revising the titles to MS-DRGs 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator), 469 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement), and 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC). These MS-DRGs continue to be subject to the replaced devices offered without cost or with a credit policy, effective October 1, 2017.
LTCH PPS FY 2018 Update

2018 LTCH PPS Rates and Factors

The FY 2018 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2018 Final Rule Tables webpage. Other FY 2018 LTCH PPS Factors are in MAC Implementation File 2 available on the FY 2018 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 35.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2017, and on or before September 30, 2018.

A. Application of the Site Neutral Payment Rate

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

The application of the site neutral payment rate is codified in the regulations at § 412.522 (80 FR 49601-49623). Section 15009 of the 21st Century Cures Act establishes a temporary exception to the application of the site neutral payment rate for certain spinal cord specialty hospitals, effective for discharges occurring during such LTCHs' cost reporting periods beginning during FY 2018 and FY 2019. Section 15010 of the 21st Century Cures Act establishes a temporary exception to the site neutral payment rate for certain severe wound discharges from certain LTCHs for cost reporting periods beginning during FY 2018. Information on the requirements implementing these temporary exceptions is available in CRs 10182 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1883OTN.pdf and 10185 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1895OTN.pdf, respectively.

The provisions of section 1206(a) of Public Law 113-67 establishes a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which is implemented in the regulations at § 412.522(c)(1). The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted. This transitional blended payment rate for site neutral payment rate LTCH discharges is included in the Pricer logic.

Effective with discharges occurring in LTCHs' cost reporting periods beginning on or after October 1, 2017 (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based on 100 percent of the site neutral payment rate for the discharge.
B. Changes to the Short-Stay Outlier (SSO) Payment Adjustment

CMS is revising the payment formula used to determine payments for SSO cases beginning in FY 2018. This change is reflected in the LTCH PPS Pricer logic.

Effective for LTCH PPS discharges occurring on or after October 1, 2017, the adjusted payment for a SSO case is equal to the “blended payment amount option” under the previous SSO policy. That is, the adjusted payment for a SSO case is equal a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem, and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount. Note there has been no change in the definition of a SSO case (and it continues to be for discharges where the covered length of stay that is less than or equal to five sixths of the geometric average length of stay for each MS-LTC–DRG).

C. Changes to High-Cost Outlier (HCO) Payments for LTCH PPS Standard Federal Payment Rate Cases

When CMS implemented the LTCH PPS, it established a policy allowing for HCO payments to cases where the estimated cost of the case exceeds the outlier threshold. In general, the outlier threshold is the LTCH PPS payment plus a fixed-loss amount that is determined annually. Historically, CMS set this threshold so that aggregate estimated HCO payments accounted for 8 percent of the estimated total aggregate payments to LTCH PPS Standard Federal payment rate cases. In addition, to ensure these estimated HCO payments did not increase or decrease its estimated payments to LTCH PPS Standard Federal Payment Rates, CMS reduced the LTCH PPS Standard Federal payment rate by 8 percent.

Section 15004(b) of the 21st Century Cures Act (Pub. L. 114-255) requires that beginning in FY 2018, CMS continue to reduce the LTCH PPS standard Federal payment rate by 8 percent, but establish the HCO fixed-loss amount so that aggregate HCO payments are estimated to be 7.975 percent of estimated aggregate payments for standard Federal payment rate cases. Accordingly, the FY 2018 fixed-loss amount of $27,381 for LTCH PPS Standard Federal Payment Rate cases reflects this statutory requirement.

D. LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2018, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

E. Provider Specific File (PSF)

The PSF required fields for all provider types which require a PSF is available in the Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf.
As noted above in section A.1., effective with discharges occurring in LTCHs’ \textbf{cost reporting periods beginning on or after October 1, 2017} (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based 100 percent of the site neutral payment rate for the discharge. \textbf{MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.}

Table 8C contains the FY 2018 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2018 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2018, Statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital’s provider agreement in accordance with 42 CFR 489.18).
2. LTCHs with a total CCR is in excess of 1.280 (referred to as the total CCR ceiling).
3. Any hospital for which data to calculate a CCR is not available.

\textbf{NOTE}: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the Medicare Claims Processing Manual.

\textbf{F. Cost of Living Adjustment (COLA) under the LTCHPPS}

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The COLAs, which have been updated for FY 2018, and effective for discharges occurring on or after October 1, 2017, can be found in the FY 2018 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2018 MAC Implementation Files webpage. (Note that the same COLA factors are used under the IPPS and the LTCH PPS for FY 2018.)

\textbf{G. 25-percent Threshold Policy}

Section 15006 of the 21st Century Cures Act established a moratorium on the implementation of the 25-percent threshold policy until October 1, 2017. CMS also established an additional regulatory moratorium on the implementation of the 25-percent threshold policy effective until October 1, 2018. CMS codified changes to the regulations at § 412.538 in the FY 2018 final rule.

\textbf{H. Average Length of Stay Calculation}

Section 15007 of the 21st Century Cures Act excluded Medicare Advantage and site neutral discharges from the calculation of the average length of stay for all LTCHs. CMS codified changes to the regulations at § 412.23(e)(3) in the FY 2018 final rule.
I. Discharge Payment Percentage

Beginning with LTCHs’ FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their “discharge payment percentage” (DPP), which is the ratio (expressed as a percentage) of the LTCHs’ FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs’ total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon final settlement of the cost report.

J. Extended Neoplastic Disease Care Hospitals

Section 15008 of the 21st Century Cures Act removed certain hospitals, previously referred to as “subclause (II) LTCHs,” from the IPPS-exclude hospital designation of an LTCH and created a new category of IPPS-excluded hospital for these entities, now referred to as “extended neoplastic disease care hospitals.” As such, these hospitals are no longer subject to the LTCH PPS effective with cost reporting periods beginning on or after January 1, 2015.

Section 15008 of the 21st Century Cures Act further specifies that, for cost reporting periods beginning on or after January 1, 2015, payment for inpatient operating costs for such hospitals is to be made as described in 42 CFR 412.526(c)(3), and payment for capital costs is to be made as described in 42 CFR 412.526(c)(4). (Note that any prior instructions issued by CMS for the payment of such hospitals redesignated by Section 15008 of the 21st Century Cures Act for cost reporting periods beginning on or after January 1, 2015 (for example, CR 9912, any references to “subclause (II) LTCHs” shall be read as “extended neoplastic disease care hospitals”.)

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital’s target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2018 final rule, CMS established an update to an extended neoplastic disease care hospital’s target amount for FY 2018 of 2.7 percent.

ADDITIONAL INFORMATION


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
## DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>October 18, 2017</td>
<td>This article was revised to reflect a revised CR10273 issued on October 17. The CR was revised to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment to the CR. The article was updated accordingly. All other information remains the same.</td>
</tr>
<tr>
<td>September 11, 2017</td>
<td>Initial article released.</td>
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</tbody>
</table>

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