DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Related Change Request (CR) #: 8041

Related CR Release Date: January 4, 2013

Effective Date: October 1, 2012

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Implementation Date: October 1, 2012

Fiscal Year (FY) 2013 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS Changes

Note: This article was revised on January 8, 2013, to reflect the revised CR8041 issued on January 4, 2013. In the article, the CR release date, transmittal number, and the Web address for accessing CR8041 have been revised. All other information remains the same.

Provider Types Affected

This MLN Matters® article is intended for hospitals that submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for acute care hospital services and long-term care hospital services.

Provider Action Needed

This article is based on Change Request (CR) 8041 which provides:

- Fiscal Year (FY) 2013 updates to the Acute Care Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCHs) Prospective Payment System (PPS), and

- FY 2013 changes to the Medicare Severity Diagnosis Related Groups (MS-DRGs) Grouper and Medicare Code Editor (MCE).

All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2012, unless otherwise noted. Be sure your billing staffs are aware of these changes.

Background

Change Request (CR) 8041 outlines changes to the Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and the Prospective Payment System (PPS) for Long-Term Care Hospitals (LTCHs) for Fiscal Year (FY) 2013. Updates to the Medicare Claims Processing Manual (Publication 100-04, Chapter 3 (Inpatient Hospital Billing) are also incorporated within CR 8041.

The policy changes for FY 2013 were displayed in the Federal Register on August 01, 2012, with a publication date of August 31, 2012.

The FY 2013 Hospital Inpatient PPS (IPPS) final rule can be found at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html on the CMS website. The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to:

- The Final Rule (display version or published Federal Register version) with 1) changes to the Acute Care Hospital IPPS and FY 2013 Rates and 2) changes to the LTCH PPS and FY 2013 Rates, and all subsequent published correction notices (if applicable);
- All tables;
- Additional data and analysis files; and
- The impact file.

Files related to the Long-Term Care PPS can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html on the CMS website.

All items covered in CR 8041 are effective for hospital discharges occurring on or after October 1, 2012, unless otherwise noted.

MS-DRG Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed new MS-DRG Grouper, Version 30.0, software package effective for discharges on or after October 1, 2012. The GROUPER assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The MCE Version 30.0, which is also developed by 3M-HIS, uses the ICD-9-CM codes to validate coding for discharges on or after October 1, 2012.

Users of the MCE should be aware that there is a new edit effective October 1, 2012; Edit 19-Procedure inconsistent with length of stay. ICD-9-CM procedure code 9672 should only be coded on claims with a length of stay of four days or greater. The length of stay will be determined by counting

the days between the from and through dates of the claim (minus any days in occurrence span code 74). Claims will be returned to provider indicating a length of stay conflict if less than 4 consecutive days. Systems changes were made to pass this information to the MCE.

IPPS FY 2013 Update

The FY 2013 IPPS Pricer is released to the FISS for discharges occurring on or after October 1, 2012. Refer Table to 1 for the FY 2013 IPPS Rates and Factors.

Attachment Table 1--FY 2013 IPPS Rates and Factors

Standardized Amount Applicable Percentage Increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Hospital Specific Applicable Percentage Increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Common Fixed Loss Cost Outlier Threshold	$21,821
Federal Capital Rate	$425.49
Puerto Rico Capital Rate	$207.25
Outlier Offset-Operating National	0.948999
Outlier Offset-Operating Puerto Rico	0.94476
SCH Budget Neutrality Factor	0.998431
SCH Documentation and Coding Adjustment Factor	0.9480

Operating Rates

Rates with Full Market Basket and Wage Index > 1	
National Labor Share	$3,679.95
National Non Labor Share	$1,668.81
PR National Labor Share	$3,679.95
PR National Non Labor Share	$1,668.81
Puerto Rico Specific Labor Share	$1,564.17
Puerto Rico Specific Non Labor Share	$954.62
Rates with Full Market Basket and Wage Index < or = 1	

National Labor Share	$3,316.23
National Non Labor Share	$2,032.53
PR National Labor Share	$3,316.23
PR National Non Labor Share	$2,032.53
Puerto Rico Specific Labor Share	$1,561.65
Puerto Rico Specific Non Labor Share	$957.14
Rates with Reduced Market Basket and Wage Index > 1	
National Labor Share	$3,607.65
National Non Labor Share	$1,636.02
PR National Labor Share	$3,679.95
PR National Non Labor Share	$1,668.81
Puerto Rico Specific Labor Share	$1,564.17
Puerto Rico Specific Non Labor Share	$954.62
Rates with Reduced Market Basket and Wage Index < or = 1	
National and PR National Labor Share	$3,251.08
National and PR National Non Labor Share	$1,992.59
PR National Labor Share	$3,316.23
PR National Non Labor Share	$2,032.53
Puerto Rico Specific Labor Share	$1,561.65
Puerto Rico Specific Non Labor Share	$957.14

Post-acute Transfer and Special Payment Policy

There are no changes to the Post-acute and Special Post-acute payment policy or applicable DRGs for FY 2013.

See Table 5 of the FY 2013 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html on the CMS website.

NEW Technology Add-On Payments

The following items are eligible for new-technology add-on payments in FY 2013:

- Continue payments for the AutoLITT™- Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9 (ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). The maximum add-on payment for a case involving the AutoLITT™ is $5,300.
- New for FY 2013- DIFICID- Cases involving DIFICID that are eligible for the new technology add-on payment will be identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is $868.
- New for FY 2013- Zenith Fenestrated Graft- Cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50.
- New for FY 2013- Voraxaze- Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000.

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Expiration of Section 508 Reclassifications

Section 508 of the 2003 Medicare Modernization Act (MMA; see http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf) and as extended by both the Affordable Care Act (see http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf) and the Middle Class Tax Relief and Job Creation Act of 2012 (see http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf) is no longer in effect as of April 1, 2012.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A of CR 8041 (Section 505) shows the IPPS providers that will be receiving a "special" wage index for FY 2013 (i.e., receive an out-commuting adjustment under section 505 of the MMA; see http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf).

Treatment of Certain Providers Re-designated Under Section 1886(d)(8)(B) of the Social Security Act

The Code of Federal Regulations (42 CFR 412.64(b)(3)(ii); see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl) implements the Social Security Act

(section 1886(d)(8)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm), which re-designates 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 re-designated.

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.

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under 42 CFR 412.103

An urban hospital that reclassifies as a rural hospital is considered rural for all IPPS purposes.

Note, hospitals reclassified as rural under 42 CRF 412.103 (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&rgn=div5&view=text&node=42:2.0.1.2.12&idno=42) are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1)).

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

The special payment protections provided to a Medicare dependent small rural hospital (MDH) are not authorized by statute beyond FY 2012. Therefore, beginning in FY 2013, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the Federal rate. (CMS notes that they have revised their SCH policy to allow MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program, as explained further in this instruction.)

Sole Community Hospital (SCH) Clarification and Changes to Effective Dates for SCH Classification

The Code of Federal Regulations (42 CFR 412.92 (b)(2) and (b)(3); see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.2&idno=42) address the effective dates of a classification as an SCH and the duration of this classification. Currently, a hospital's SCH classification status remains in effect without the need for re-approval unless there is a change in the circumstances under which the classification was approved. The Code of Federal Regulations (42 CRF 412.92(b)(3)) requires a hospital to notify the FI or MAC within 30 days of a change that could affect its classification as an SCH. The existing language at 42 CFR 412.92(b)(3) only refers to a hospital becoming aware of a "change," because it deals specifically with a situation where a hospital was appropriately classified as an SCH because it had previously met the requirements to become an SCH. However, the regulations did not explicitly address the situation where a hospital never met the requirements to be classified as an SCH, but was incorrectly classified as an SCH.

In light of the fact that CMS found a number of providers who may have been classified as SCHs incorrectly, in the FY 2013 rule, CMS discusses the current authority to recoup any overpayments

associated with the incorrect SCH status, consistent with the cost report reopening rules at 42 CFR 405.1885 (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=04bc29d77e11df84ab4b97b2649fb8cc&rgn=div8&view=text&node=42:2.0.1.2.5.11.33.48&idno=42), and to cancel the hospital's classification retroactively. As a result, CMS has the discretion to reopen cost reports within the 3-year reopening period and cancel a hospital's SCH status.

Additionally, effective October 1, 2012, if a hospital reports any factors or information to CMS that could have affected its initial classification as an SCH and CMS then determines that, based on the additional information, the hospital should not have qualified for SCH status, CMS will cancel SCH status effective beginning with 30 days from the CMS' date of determination.

Current regulations state that if a hospital qualifies for SCH status, that status is generally effective beginning 30 days after CMS' written notification of approval. Due to the expiration of the MDH provision on September 30, 2012, there may be a number of hospitals currently classified as MDHs under 42 CFR 412.108 (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.13&idno=42 on the Internet) that believe they qualify for classification as SCHs under 42 CFR 412.92. In the FY 2013 IPPS/LTCH PPS final rule, CMS revised the regulations to provide for an exception to the effective date of SCH classification for any MDH that:

- Applies for SCH status at least 30 days prior to the expiration of the MDH provision (that is, by August 31, 2012), and
- Requests that SCH status be effective with the expiration of the MDH provision and the hospital is approved for SCH status.

The effective date of SCH status for those MDHs that comply with the application requirements and qualify for SCH status is the day following the expiration date of the MDH provision, that is, October 1, 2012.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2013

For FYs 2011 and 2012, the Affordable Care Act expanded the definition of a low volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Beginning with FY 2013, the low volume hospital definition and payment adjustment will revert to the policies that were in effect prior to the amendments made by the Affordable Care Act. Therefore, as specified under the regulations at 42 CRF 412.101 (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.6&idno=42), effective for FY 2013 and subsequent years, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another "subsection (d) hospital" and have less than 200 total discharges (including both Medicare and non Medicare discharges) during the fiscal year. For FY 2013 and subsequent years, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

The FI/MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The FI/MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria. For FY 2013 (and subsequent years), the FI/MAC makes the discharge determination based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges. The hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume hospital payment adjustment for the current year (see 42 CFR 412.101(b)(2)(i)). To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2013 (and subsequent years), a hospital must be located more than 25 road miles (as defined at 42 CFR 412.101(a)) from the nearest "subsection (d) hospital" (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its FI/ MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The FI/ MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the FI/ MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In order to receive the low-volume hospital payment adjustment for FY 2013, a hospital must meet both the discharge and mileage criteria (set forth at 42 CFR 412.101(b)(2)(i)).

For FY 2013, a hospital should make its request for low-volume hospital status in writing to its FI/MAC and provide documentation that it meets the mileage criterion by September 1, 2012, so that the 25 percent low-volume hospital adjustment can be applied to payments for its discharges occurring on or after October 1, 2012 (through September 30, 2013). For requests for low-volume hospital status for FY 2013 received after September 1, 2012, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the 25 percent low-volume hospital adjustment in determining payments to the hospital's FY 2013 discharges prospectively within 30 days of the date of the FI's/MAC's low-volume hospital status determination.

The 25 percent low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH, IME and outliers. For SCHs, 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.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at *https://www.qualitynet.org* on the Internet. This website is expected to be updated in September 2012. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website, and FIs and A/B MACs shall update the provider file as needed. A list of hospitals that will receive the 2.0

percent reduction to the annual payment update for FY 2013 under the Hospital Inpatient Quality Reporting (IQR) Program will be available in September 2012.

Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act (see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm) establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR 412 (§412.150 through §412.154) as established in the FY 2013 IPPS/LTCH PPS final rule.

In the FY 2012 IPPS/LTCH PPS final rule, CMS finalized the readmission measures for Acute Myocardial Infarction, (AMI), Heart Failure (HF) and Pneumonia (PN) and the calculation of the excess readmission ratio, which is used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a subsection (d) hospital within 30 days of a discharge from the same or another subsection (d) hospital. CMS finalized the calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios. The excess readmission ratio includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty. Finally, CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio is based on discharges occurring during the 3 year period of July 1, 2008 to June 30, 2011. For more information on the readmissions measures, please refer to the FY 2012 IPPS/ LTCH PPS Final Rule at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2012-IPPS-Final-Rule-Home-Page.html on the CMS website.

In the FY 2013 IPPS/LTCH PPS final rule, CMS finalized that "subsection (d) hospitals" are subject to the Hospital Readmissions Reduction Program, which excludes Puerto Rico hospitals. In addition, CMS has exempted Maryland hospitals from the Hospital Readmissions Reduction Program for FY 2013. In the FY 2013 IPPS/ LTCH PPS final rule, CMS established the methodology to calculate the hospital readmissions adjustment factor, what portion of the IPPS payment will be used to calculate the readmissions adjustment amount and CMS has established a process for hospitals to review their readmissions information and submit corrections to the information before the readmission rates are to be made public.

For FY 2013, the readmissions adjustment factor is the higher of a ratio or 0.99 (-1 percent). The methodology to calculate the ratio is discussed in the FY 2013 IPPS/ LTCH PPS final rule. The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount," or the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS

payment due to excess readmissions. Add-on payments for IME, DSH, outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2013, such as Maryland hospitals, will have a readmissions adjustment factor of 1.0000. For FY 2013, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9900. (The readmissions adjustment factors for FY 2013 are shown in Table 15 listed in the Addendum to the FY 2013 IPPS/LTCH PPS final rule.) Hospitals that are not included in the Hospital Readmissions Reduction Program, such as Puerto Rico hospitals, will not have a readmissions adjustment factor.

Hospital Value-Based Purchasing Program

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act (see see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm), establishing the Hospital Value-Based Purchasing (VBP) Program. This program results in adjustments to base operating DRG payment amounts for discharges from subsection (d) hospitals, for discharges beginning in FY 2013. CMS has excluded Maryland hospitals from the Hospital VBP Program for the FY 2013 program year. CMS will not implement the FY 2013 payment adjustments under the Hospital VBP Program until January 2013. The regulations that implement this provision are in subpart I of 42 CFR 412 (§412.160 through §412.162) as established in the FY 2013 IPPS/LTCH PPS final rule.

Under the Hospital VBP Program, CMS will reduce base operating DRG payment amounts for subsection (d) hospitals by the applicable percent, beginning with discharges occurring in FY 2013. The applicable percent for payment reductions for FY 2013 is 1.0 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS will calculate a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS will then use a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS will calculate a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSs and submit requests for corrections to the information before it is made public.

For FY 2013, as noted above, CMS will not implement the base operating DRG payment amount reductions or the value-based incentive payment adjustments until January 2013. Claims for discharges occurring in FY 2013 that are paid prior to this January 2013 implementation will be reprocessed by CMS as quickly as practicable.

Recalled Devices

As a reminder, section 2202.4 of the Provider Reimbursement Manual, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

Bundled Payments for Care Improvement Initiative (BPCI) Model 1

CMS is working in partnership with providers to develop models of bundling payments through the BPCI initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In Model 1, the episode of care is defined as the acute care hospital stay only. Applicants for this model will propose a discount percentage which will be applied to payment for all participating hospitals' DRG over the lifetime of the initiative. Participating hospitals may gainshare with physicians any internal hospital savings achieved from redesigning care if they can reduce hospital costs for the episode below the discount provided to CMS as part of their agreement. More information may be found at http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html on the CMS website.

For hospitals participating in Model 1 of the BPCI, a standard discount will be taken from all DRG payments made to the hospital. The discount will be phased in over time, with the discount amount updated as frequently as every six months. This adjustment will be made to the base operating DRG (as defined earlier in this change request). IME, DSH, and outlier payments will be calculated based on the nondiscounted base payments.

LTCH PPS FY 2013 Update

The FY 2013 LTCH PPS Rates and Factors are as follows:

Federal Rate for discharges from 10/1/12 through 12/28/12	$40,915.95
Federal Rate for discharges from 12/29/12 through 9/30/13	$40,397.96
High Cost Outlier Fixed-Loss Amount	$15,408
Labor Share	63.096%
Non-Labor Share	36.904%

The LTCH PPS Pricer has been updated with the Version 30.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2012, and on or before September 30, 2013.

Short Stay Outlier (SSO) Payment Formula

The statutory 5-year moratorium on the application of the "IPPS comparable per diem amount" option under the short-stay outlier (SSO) payment adjustment expires for discharges beginning on or after December 29, 2012. With the expiration of the moratorium, the existing SSO payment formula is revised for those cases where the patient's covered length of stay (LOS) is less than or equal to the "IPPS comparable threshold" for the MS-LTC-DRG to which the case is assigned. The "IPPS-comparable threshold" is defined as one standard deviation from the geometric average length of stay for the same MS-DRG under the IPPS (as shown in Table 11 listed in the Addendum to the FY 2013 IPPS/LTCH PPS final rule and available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1588-F.html). If the covered LOS of an LTCH SSO case is within the "IPPS-comparable threshold", the "IPPS comparable per diem amount" (capped at the full "IPPS comparable amount") option will replace the "blend amount" option in the current SSO payment formula.

For a SSO discharge occurring on or after December 29, 2012, the Medicare payment will be based on the least of the following:

- 100 percent of the estimated cost of the case;
- 120 percent of the MS-LTC DRG specific per diem amount multiplied by the covered length of stay of the particular case;
- The full MS-LTC-DRG per diem amount;
- Comparing the covered length of stay for the SSO case and the "IPPS comparable threshold," one of the following:
  a) A blend of the 120 percent of the MS-LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount, for cases where the covered length of stay for the SSO case is greater than the "IPPS comparable threshold";

  b) An amount comparable to the IPPS comparable per diem amount, if the covered length of stay for an SSO case is equal to or less than one standard deviation from the geometric average length of stay for the same MS-DRG under the IPPS (the "IPPS comparable threshold").

The IPPS comparable per diem amount is determined by the same methodology as the IPPS comparable per diem portion of the current "blend amount" option. For SSO cases where the covered LOS exceeds the "IPPS comparable threshold," payment is made under the existing SSO policy, as specified above.

Cost of Living Adjustment (COLA) Update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Core-Based Statistical Area (CBSA)-based Labor Market Area Updates

There are no changes to the Core-Based Statistical Area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2013. The CBSAs definitions and codes that will continue to be effective October 1, 2012, can be found in Table 12A listed in the Addendum of the FY 2013 IPPS/LTCH PPS final rule, which is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1588-F.html on the CMS website.

Additional LTCH PPS Policy Changes for FY 2013

The 5-year statutory moratorium on the full-implementation of the "25 percent threshold" payment adjustment for LTCH discharges admitted from individual referring hospitals expires for LTCH cost reporting periods beginning on or after July 1, 2012 or October 1, 2012, as applicable. In the FY 2013 IPPS/LTCH PPS final rule, CMS extended the moratorium on the implementation of the "25 percent threshold" payment policy effective for cost reporting periods beginning on or after October 1, 2012, and before October 1, 2013. For certain LTCHs and LTCH satellites with cost-reporting periods beginning on or after July 1, 2012, and before October 1, 2012, CMS also provided a supplemental moratorium effective for discharges occurring on or after October 1, 2012, and through the end of the cost reporting period. For additional details, refer to the discussion in the FY 2013 IPPS/LTCH PPS final rule.

The 5-year statutory moratorium on the development of new LTCHs and LTCH satellite facilities and an increase in number of LTCH beds initially provided in section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA; see http://www.gpo.gov/fdsys/pkg/PLAW-110publ173/html/PLAW-110publ173.htm), will expire on December 29, 2012.

Additional Information

The official instruction, CR 8041, issued to your FIs and A/B MACs regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2627CP.pdf on the CMS website.

You can find the home page for the FY 2013 Hospital Inpatient PPS (IPPS) final rule at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html on the CMS website. The IPPS home page centralizes file(s) related to the IPPS proposed rule, and it contains links to: the proposed rule (display version or published Federal Register version) and all subsequent published correction notices (if applicable); all tables; additional data and analysis files; and the impact file.

Files related to the Long Term Care PPS can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html on the CMS website.

If you have any questions, please contact your FIs and/or A/B MACs at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.