

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



News Flash –

Revised product from the Medicare Learning Network® (MLN)

- [“Long Term Care Hospital Prospective Payment System: Short-Stay Outliers,”](#) Fact Sheet, ICN 006394, Downloadable only.

MLN Matters® Number: MM8214

Related Change Request (CR) #: CR 8214

Related CR Release Date: March 1, 2013

Effective Date: October 1, 2012

Related CR Transmittal #: R11950TN

Implementation Date: April 1, 2013

## **Inpatient Prospective Payment System (IPPS) Hospital Payment Extensions per the American Taxpayer Relief Act of 2012**

### **Provider Types Affected**

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This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

### **Provider Action Needed**

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This article is based on Change Request (CR) 8214 which provides information and implementation instructions for Sections 605 and 606 of the American Taxpayer Relief Act of 2012. See the Background and Additional Information Sections of this article for further details regarding these changes. Also, make sure that your billing staffs are aware of these changes.

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## Background

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On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act (ATRA) of 2012. See <http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf> on the Internet.

The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (see <http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf> on the Internet). It also extends several provisions of the Affordable Care Act (see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf> on the Internet).

Specifically, the following Medicare Fee-For-Service (FFS) policies (with October 1, 2012, effective dates) have been extended.

### **Section 605 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals**

The Affordable Care Act provided for temporary changes to the qualifying criteria and payment adjustment for low-volume hospitals for fiscal years (FYs) 2011 and 2012. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This ATRA provision extends those temporary changes to the low-volume hospital payment adjustment through September 30, 2013, retroactive to October 1, 2012.

### **Section 606 - Extension of the Medicare-Dependent Hospital (MDH) Program**

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This ATRA provision extends the MDH program until October 1, 2013, and is retroactive to October 1, 2012.

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

Sections 3125 and 10314 of the Affordable Care Act amended the low-volume hospital adjustment in Section 1886(d)(12) of the Social Security Act by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. Prior to the recently enacted ATRA, beginning with FY 2013, the low-volume hospital qualifying criteria and payment adjustment had returned to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act. Section 605 of the ATRA extends, for FY 2013, the temporary changes in the low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act. The Centers for Medicare & Medicaid Services (CMS) implemented the changes to the low-volume payment adjustment provided by the Affordable Care Act in the regulations at 42 CFR 412.101 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275) and intends to make conforming changes to the regulations at 42 CFR 412.101 for the provisions of section 605 of the ATRA in future rulemaking. You can review 42 CFR 412.101 at

[http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=62266c93cbd0d7a0f60ac0310d069e63&tpl=/ecfrbrowse/Title42/42cfr412\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=62266c93cbd0d7a0f60ac0310d069e63&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl) on the Internet.

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To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2013 provided for by Section 605 of the ATRA, in accordance with the existing regulations at 42 CFR 412.101(b)(2)(ii) and consistent with the CMS implementation of those changes in FYs 2011 and 2012, CMS published a notice in the Federal Register (CMS-1588-N) updating the discharge data source used to identify qualifying low volume hospitals and calculate the payment adjustment (percentage increase) for FY 2013.

In that notice, CMS established that for FY 2013, the low-volume payment adjustment will be determined using FY 2011 Medicare discharge data from the March 2012 update of the MedPAR files. In Table 14 of the Addendum to that notice, CMS provides a list of the Inpatient Prospective Payment System (IPPS) hospitals with fewer than 1,600 Medicare discharges based on the March 2012 update of the FY 2011 MedPAR files. However, this list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment in FY 2013 since it does not reflect whether or not the hospital meets the mileage criterion (that is, to qualify for the low-volume adjustment, the hospital also must be located more than 15 road miles from any other IPPS hospital). **In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2013, a hospital must meet both the discharge and mileage criteria.**

In order to receive a low-volume hospital payment adjustment for FY 2013, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its FI or MAC that it meets the mileage criterion. For FY 2013, a hospital should make its request for low-volume hospital status in writing to its FI or MAC and provide documentation that it meets the mileage criterion by March 22, 2013, so that the applicable low-volume percentage increase can be applied to payments for its discharges occurring on or after October 1, 2012, (that is, the beginning of FY 2013). A hospital that qualified for the low-volume payment adjustment in FY 2012 may continue to receive a low-volume payment adjustment in FY 2013, without reapplying, if it continues to meet the Medicare discharge criterion, based on the FY 2011 MedPAR data (shown in Table 14 of the Federal Register notice (available on the Internet as noted below) and the distance criterion. **However, the hospital must verify in writing to its FI or MAC that it continues to be more than 15 miles from any other "subsection (d)" hospital no later than March 22, 2013, in order for the applicable low-volume percentage increase be applied retroactively to payments for discharges occurring on or after October 1, 2012.** For requests for low-volume hospital status for FY 2013 received after March 22, 2013, if the hospital meets the criteria to qualify as a low-volume hospital, the FI or MAC will apply the applicable low-volume payment adjustment in determining payments to the hospital's FY 2013 discharges prospectively effective within 30 days of the date of the FIs or MACs low-volume status determination.

FIs/MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2012 update of the FY 2011 MedPAR files as shown in Table 14 of the Federal Register Notice (CMS-1588-N) and available on the Internet 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 2013 IPPS Final Rule Home Page"). (CMS notes that in order to facilitate administrative

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implementation, the only source that CMS and the FIs/MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2013 is the data from the March 2012 update of the FY 2011 MedPAR file.)

The applicable low-volume payment adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), Indirect Medical Education (IME), and outliers. For Sole-Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs), the applicable low-volume percentage increase 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.

### **Reinstatement of Medicare Dependent Hospital (MDH) status**

In section 606 of the ATRA, Congress reinstated the MDH program which had expired as of October 1, 2012. Generally, providers that were classified as MDHs prior to the expiration of the MDH provision will be reinstated as MDHs effective October 1, 2012, with no need to reapply for MDH classification. There are two exceptions:

- **MDHs that classified as Sole-Community Hospitals (SCHs) on or after October 1, 2012** - In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by August 31, 2012, to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification, received SCH status as of October 1, 2012. Additionally, some hospitals that had MDH status as of the September 30, 2012 expiration of the MDH program may have missed the August 31, 2012 application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than October 1, 2012.
- **MDHs that requested a cancellation of their rural classification** - In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR 412.103 at [http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=62266c93cbd0d7a0f60ac0310d069e63&tpl=/ecfrbrowse/Title42/42cfr412\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=62266c93cbd0d7a0f60ac0310d069e63&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl) on the Internet. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2012. All other former MDHs will be automatically reinstated as MDHs effective October 1, 2012. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations. Specifically, the regulations at 42 CFR 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (412.108(b)(2)).

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2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (412.108(b)(4)).

### **Cancellation of MDH status**

As required by the regulations at 42 CFR 412.108(b)(5), Medicare contractors must “**evaluate on an ongoing basis**” whether or not a hospital continues to qualify for MDH status. Therefore, the contractors will ensure that the hospital continues to meet the MDH criteria and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers do not qualify as MDHs, based on their Medicare utilization rates not meeting the threshold for MDH classification, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2012, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

### **Claims Processing**

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Note that any claims impacted by the above provisions, i.e., those with a discharge date on or after October 1, 2012, through the implementation of the IPPS Pricer on April 1, 2013, will be reprocessed by your Medicare contractor. Further, such claims should be reprocessed on or before June 30, 2013.

### **Additional Information**

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The official instruction, CR8214 issued to your FIs and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1195OTN.pdf> on the CMS website.

If you have any questions, please contact your FIs 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.

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