DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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- "Hospital Outpatient Prospective Payment System" Fact Sheet (ICN 006820), Downloadable

MLN Matters® Number: MM8627 **Related Change Request (CR) #: 8627**

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Inpatient Prospective Payment System (IPPS) Hospital Extensions per the Pathway for SGR Reform Act of 2013

Provider Types Affected

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Claims Administration Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8627 which provides information and implementation instructions for Sections 1105 and 1106 of the Pathway for SGR (Medicare Sustainable Growth Rate) Reform Act of 2013. Make sure your billing staffs are aware of these changes.

Background

On December 26, 2013, the President signed into law the Pathway for SGR (Medicare Sustainable Growth Rate) Reform Act of 2013, and the new law includes the extension of

certain provisions of the Affordable Care Act. Specifically, the following Medicare Fee-For-Service (FFS) policies have been extended through March 31, 2014:

- **Section 1105 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals**

The Affordable Care Act provided for temporary changes to the low-volume hospital adjustment 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. The temporary changes to the low-volume hospital adjustment were extended for FY 2013 by the American Taxpayer Relief Act (ATRA). This provision extends those temporary changes to the payment adjustment through March 31, 2014, retroactive to October 1, 2013.

- **Section 1106 - 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 provision extends the MDH program until March 31, 2014, and it is retroactive to October 1, 2013.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2014

The Affordable Care Act (Sections 3125 and 10314) amended the low-volume hospital adjustment in the Social Security Act (Section 1886(d)(12); see **http://www.ssa.gov/OP_Home/ssact/title18/1886.htm** on the Internet) by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. These amendments were extended for FY 2013 by Section 605 of the ATRA. Prior to the recently enacted Pathway for SGR Reform Act of 2013, beginning with FY 2014, 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 and the ATRA. The Pathway for SGR Reform Act of 2013 (Section 1105) extends, for FY 2014 discharges occurring before April 1, 2014, the temporary changes in the low-volume hospital payment policy provided for by the Affordable Care Act, as amended by the ATRA. The Centers for Medicare & Medicaid Services (CMS) implemented the changes to the low-volume payment adjustment provided by the Affordable Care Act and the ATRA in:

- The regulations at 42 CFR 412.101 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275; see **http://www.gpo.gov/fdsys/pkg/FR-2010-08-16/html/2010-19092.htm**), and
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50611 through 50613; see **http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm** on the Internet).

You can review 42 CFR 412.101 at **http://www.ecfr.gov/cgi-bin/text-idx?SID=c2e502868ec2817574e80c0791868945&node=42:2.0.1.2.12.7.50.6&rgn=div8** on the Internet.

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2014 discharges occurring before April 1, 2014, provided for by the Pathway for SGR Reform Act of 2013 (Section 1105), in accordance with the existing regulations at 42 CFR 412.101(b)(2)(ii) and consistent with the CMS implementation of the low-volume hospital payment adjustment in FYs 2011 through 2013, CMS published an interim final rule with comment (IFC) in the Federal Register (CMS-1599-IFC2) updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2014 discharges that occur before April 1, 2014. CMS-1599-IFC2 is available at **http://www.ofr.gov/OFRUpload/OFRData/2014-05922_PI.pdf** on the Internet.

In that IFC, CMS established for FY 2014 discharges occurring before April 1, 2014, the low-volume payment adjustment will be determined using FY 2012 Medicare discharge data from the March 2013 update of the MedPAR files. In Table 14 of the Addendum of the IFC, CMS provides a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files. 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 for FY 2014 discharges occurring before April 1, 2014, 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 must also 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 2014 discharges occurring before April 1, 2014, a hospital must meet both the discharge and mileage criteria.**

In order to receive a low-volume hospital payment adjustment for FY 2014 discharges occurring before April 1, 2014, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its MAC that it meets the mileage criterion. Specifically, a hospital must make its request for low-volume hospital status in writing to its MAC and provide documentation that it meets the mileage criterion, so that the applicable low-volume percentage increase is applied to payments for its discharges occurring on or after October 1, 2013 (that is, the beginning of FY 2014).

The MAC must be in receipt of the hospital's written request by March 31, 2014, in order for the effective date of the hospital's low status to be October 1, 2013. A hospital that qualified for the low-volume payment adjustment in FY 2013 may continue to receive a low-volume payment adjustment for FY 2014 discharges occurring before April 1, 2014, without reapplying, if it continues to meet the Medicare discharge criterion, based on the FY 2012 MedPAR data (shown in Table 14 of the IFC (available on the Internet as noted below) and the distance criterion. **The hospital must verify in writing to its MAC that it continues to be more than 15 miles from any other "subsection (d)" hospital no later than March 31, 2014**. For requests for low-volume hospital status for FY 2014 discharges

occurring before April 1, 2014, received after March 31, 2014, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that would be applicable prospectively within 30 days of the date of the MAC's low-volume status determination, consistent with historical CMS policy. However, given the timing of this partial year extension of the temporary changes to the low-volume hospital payment adjustment, which expires March 31, 2014, any applicable low-volume payment adjustment will not be applied in determining payments to the hospital' s FY 2014 discharges occurring before April 1, 2014, since CMS policy does not provide for retroactive effective dates. However, in case of a future subsequent extension, the MAC should process those requests and send a letter to the hospital indicating that although the provider meets the low-volume hospital criteria for FY 2014 set forth at 412.101(b)(2)(ii), those provisions are expired under current law. In the event the temporary changes to the low-volume hospital payment adjustment are subsequently extended, then the MAC can establish the effective date as 30 days from the date of the letter.

MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files as shown in Table 14 of the IFC (CMS-1599-IFC2) and available on the Acute Inpatient PPS webpage at **http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp** on the CMS website. (click on the link on the left side of the screen titled, "FY 2014 IPPS Final Rule Home Page"). CMS notes that in order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2014 discharges occurring before April 1, 2014, is the data from the March 2013 update of the FY 2012 MedPAR file.

In order to implement this policy for FY 2014, the Pricer will include a table containing the provider number and discharge count determined from the March 2013 update of the FY 2012 MedPAR file. The discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units. The table in Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).

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), uncompensated care, 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

Under the Affordable Care Act (Section 3124), the MDH program authorized by the Social Security Act (Section 1886(d)(5)(G); see **http://www.ssa.gov/OP_Home/ssact/title18/1886.htm** on the Internet) was set to expire at

the end of FY 2012. These provisions were extended for FY 2013 by Section 606 of the ATRA. Prior to the recently enacted Pathway for SGR Reform Act of 2013, the MDH program was set to expire at the end of FY 2013. As part of the Pathway for SGR Reform Act of 2013, Congress provided for a temporary reinstatement of the MDH program which had expired as of October 1, 2013.

The Pathway for SGR Reform Act of 2013 (Section 1106) extends the MDH program through March 31, 2014. CMS implemented the extension of the MDH program provided by the Affordable Care Act and the ATRA in the regulations at 42 CFR 412.108 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50287) and the FY 2014 IPPS/LTCH PPS final rule (78 FR 50647 through 50649), respectively.

Consistent with the CMS implementation of the MDH program extension in FY 2013, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective October 1, 2013, with no need to reapply for MDH classification. There are two exceptions:

a. MDHs that classified as Sole-Community Hospitals (SCHs) on or after October 1, 2013

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by August 31, 2013, 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, 2013. Additionally, some hospitals that had MDH status as of the September 30, 2013, expiration of the MDH program may have missed the August 31, 2013 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, 2013.

b. MDHs that requested a cancellation of their rural classification under 42 CFR 412.103(b)

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 (see **http://www.ecfr.gov/cgi-bin/text-idx?SID=c2e502868ec2817574e80c0791868945&node=42:2.0.1.2.12.7.50.8&rgn=div8** on the Internet). With the expiration of the MDH program, 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, 2013. All other former MDHs will be automatically reinstated as MDHs effective October 1, 2013. Providers that fall within either of the two exceptions will have to reapply for MDH classification in

accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). 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 (42 CFR §412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (42 CFR §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 (42 CFR §412.108(b)(4)).

CMS notes, given the timing of this partial year extension of the MDH program, the current regulations governing the cancellation of SCH status 412.92(b)(4), the request for rural reclassification under 412.103, and the effective date of MDH classification at 412.108(b) may not allow for sufficient time for hospitals that have reclassified as SCHs or canceled their rural status in anticipation of the expiration of the MDH program to cancel their SCH status or request rural reclassification and then reapply and be approved for MDH status. These regulations may not allow for sufficient time for a hospital seeking to classify as an MDH to be approved prior to the March 31, 2014 expiration of the MDH program.

Cancellation of MDH Status

As required by the regulations at 42 CFR 412.108(b)(5), MACs must "**evaluate on an ongoing basis**" whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at 42 CFR 412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 42 CFR 412.108(a) 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 MAC provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2013, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Attachment 1 of CR8627 outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario. CR8627 is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1347OTN.pdf** on the CMS website.

Notification to Provider

Each MAC will notify each affected provider with information specific to that provider regarding how it is affected by the MDH program extension by notifying the provider of its status under the extension of the MDH program. The status of each former MDH will either be:

- MDH status reinstated effective October 1, 2013; or
- MDH status not reinstated; additional action required by the provider in order to be classified as an MDH.
  - The provider must request a cancellation of SCH status or submit a request for rural classification under 42 CFR 412.103 (see **http://www.ecfr.gov/cgi-bin/text-idx?SID=c2e502868ec2817574e80c0791868945&node=42:2.0.1.2.12.7.50.8&rgn=div8**). The provider will then have to reapply for MDH status in accordance with the regulations under 42 CFR 412.108(b).
- MDH status reinstated and then subsequently cancelled due to the provider not continuing to meet the criteria for MDH classification under the requirements at 42 CFR §412.108(b)(5).

Additional Information

The official instruction, CR8627 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1347OTN.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which is available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- **MLN Matters® Article #MM8433**, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- **MLN Matters® Article #SE1336**, "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- **HealthMap Vaccine Finder** - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

Free Resources can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under "Programs", select "Immunizations and Vaccines (Influenza/Flu)" for a list of flu related resources.