

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



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MLN Matters® Number: MM8900

Related Change Request (CR) #: CR 8900

Related CR Release Date: November 26, 2014

Effective Date: October 1, 2014

Related CR Transmittal #: R3138CP

Implementation October 6, 2014

Fiscal Year (FY) 2015 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

Note: This article was revised on January 6, 2015, to reflect a revised Change Request (CR). The CR was issued to correct information related to technical errors cited in the correction notice, CMS-1607-CN, published October 3, 2014. A list of the changes included in the CR may be found in the Additional Information Section of this article. The CR date, transmittal number and link to the CR also changed. 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 acute care and long-term care hospital services provided to Medicare beneficiaries.

Provider Action Needed

CR 8900 provides FY 2015 updates to the Acute Care Hospital IPPS and the LTCH PPS. All items covered in CR8900 are effective for hospital discharges occurring on or after October 1, 2014, unless otherwise noted. Make sure your billing staff are aware of these changes.

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Background

The policy changes for FY 2015 were published in the Federal Register on August 22, 2014. You can find the home page for the FY 2015 Hospital Inpatient PPS final rule at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html> on the Centers for Medicare & Medicaid Services (CMS) website. The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to the final rule and all subsequent published correction notices (if applicable); and includes:

- 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.

Key Points of CR8900

IPPS Updates

Medicare Severity Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new MS-DRG Grouper, Version 32.0, software package effective for discharges on or after October 1, 2014. The MCE selects the proper internal code edit tables based on discharge date. Note that the MCE version continues to match the Grouper.

CMS created the following new MS-DRGs for endovascular cardiac valve replacements:

- MS-DRG 266 (Endovascular Cardiac Valve Replacement w MCC); and
- MS-DRG 267 (Endovascular Cardiac Valve Replacement w/o MCC).

CMS deleted:

- MS-DRG 490 (Back & Neck Procedures except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator); and
- MS-DRG 491 (Back & Neck Procedures except Spinal Fusion without CC/MCC).

CMS created the following three new MS-DRGs to account for a separate CC severity level:

- MS-DRG 518 (Back & Neck Procedure Except Spinal Fusion w MCC or Disc Device/Neurostimulator);
- MS-DRG 519 (Back & Neck Procedure Except Spinal Fusion w CC); and

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- MS-DRG 520 (Back & Neck Procedure Except Spinal Fusion w/o CC/MCC).

Lastly, CMS modified MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities with CC/MCC) by deleting MS-DRG 484 (Major Joint/Limb Reattachment Procedure of Upper Extremities without CC/MCC) and revising the title for MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities) to create one base DRG.

Post-acute Transfer and Special Payment Policy

As a result of changes to MS-DRGs for FY 2015 the following MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- 266, 267 (Endovascular Cardiac Valve Replacement with and without MCC, respectively); and
- 518, 519, and 520 (Back & Neck Procedure except Spinal Fusion with MCC or Disc Device/Neurostimulator, with CC, and without MCC/CC, respectively).

MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities) will be removed from the list of MS-DRGs subject to the post-acute care transfer policy.

See corrected Table 5 of the FY 2015 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html> on the CMS website.

New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2015:

- 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. (For your information the ICD-10-CM procedure codes are: 04U03JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Approach; 04U04JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach; 04V03DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach or 04V04DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Endoscopic Approach.
- 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 corrected maximum add-on payment for a case involving the Voraxaze is \$47,250. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of Glucarpidase into Peripheral Vein, Percutaneous Approach or 3E043GQ - Introduction of Glucarpidase into Central Vein, Percutaneous Approach.)

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- Argus- Cases involving the Argus ®II System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 14.81. The maximum add-on payment for a case involving the Argus ®II System is \$72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach or 08H105Z - Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach.)
- Kcentra- Cases involving Kcentra that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is \$1,587.50. **DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM:** 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.7, 286.52, 286.53, or 286.59. (For your information the ICD-10-CM procedure codes are: 30280B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach or 30283B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, and D68.4.)
- Zilver- Cases involving the Zilver® PTX® that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.60. The maximum add-on payment for a case of the Zilver® PTX® is, \$1,705.25. (For your information the ICD-10-CM procedure codes are: 047K04Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047K34Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach; 047K44Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach; 047L04Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047L34Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach or 047L44Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach.)

The following items will be eligible for new-technology add-on payments in FY2015:

- CardioMEMS™ HF Monitoring System – Cases involving the CardioMEMS™ HF Monitoring System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 38.26. The maximum add-on payment is \$8,875. (For your information the ICD-10-CM procedure code is: 02HQ30Z- Insertion of Pressure Sensor Monitoring Device into Right Pulmonary Artery, Percutaneous Approach.)
- MitraClip® System - Cases involving the MitraClip® System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 35.97. The maximum add-on payment is \$15,000. (For your information, the ICD-10-CM procedure code is: 02UG3JZ Supplement Mitral Valve with Synthetic Substitute, Percutaneous Approach.)

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- RNS® System- Cases involving the RNS® System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 01.20 in combination with 02.93. The maximum add-on payment is \$18,475. (The ICD-10-CM procedure codes are: 0NH00NZ-Insertion of Neurostimulator Generator into Skull, Open Approach in combination with 00H00MZ-Insertion of Neurostimulator Lead into Brain, Open Approach.)

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 COLAs for FY 2015, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, is in the FY 2015 IPPS/LTCH PPS final rule and is also displayed in the following tables:

FY 2015 Cost-of-Living Adjustment Factors: Alaska Hospitals

Area	Cost of Living Adjustment Factor
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25

FY 2015 Cost-of-Living Adjustment Factors: Hawaii Hospitals

Area	Cost of Living Adjustment Factor
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

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FY 2015 Wage Index Changes and Issues

New Wage Index Labor Market Areas and Transitional Wage Indexes

Effective October 1, 2014, CMS is revising 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.

CMS is adopting a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This mitigates potential negative payment impacts due to the adoption of the new OMB delineations.

Under the new OMB delineations for the few hospitals that have been located in an urban county prior to October 1, 2014, that are becoming rural effective October 1, 2014, CMS is assigning a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

For FY 2015, for hospitals that are eligible for the 3-year hold-harmless transition, it is possible that receiving the FY 2015 wage index of the CBSA where the hospital is geographically located for FY 2014 might still be less than the FY 2015 wage index that the hospital would have received in the absence of the adoption of the new OMB delineations. The assignment of the 3-year transitional wage index is included in the calculation of the FY 2015 portion of the blended wage index for that hospital. After FY 2015, such a hospital will revert to the second year of the 3-year transition (assuming no other form of wage index reclassification or redesignation is granted).

Note that for hospitals that are receiving a one-year transition blended wage index or the 3-year hold-harmless wage index, these transitions are only for the purpose of the wage index and do not affect a hospital's urban or rural status for any other payment purposes.

To ensure hospitals are paid correctly under the IPPS for the policies noted above, MACs followed the steps specified in CR 8900 titled, "Updating the PSF for Wage Index, Reclassifications and Redesignations" to update the PSF.

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 Social Security 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.

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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.

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 (MGCRCB).

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

An urban hospital that reclassifies as a rural hospital under 412.103 is considered rural for all IPPS purposes. Note that 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)). Please reference Table 9C of FY 2015 Final rule available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html> on the CMS website.

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

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. The MDH program is currently effective through March 31, 2015, as provided by Section 106 of the Protecting Access to Medicare Act of 2014. Provider Types 14 and 15 continue to be valid through March 31, 2015.

Under current law, beginning in April 1, 2015, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the Federal rate. (CMS notes that the Sole Community Hospital (SCH) policy at Section 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 April 1, 2015.

Hospital Specific (HSP) Rate Update for Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)

For FY 2015, Hospital-Specific (HSP) amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2014 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond. (As noted above, under current law, the MDH program expires March 31, 2015.)

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2015

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 105 of the Protecting Access to

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Medicare Act of 2014 extended the temporary changes to the low-volume hospital payment adjustment through March 31, 2015. The regulations implementing the hospital payment adjustment policy are at 412.101.

Beginning with FY 2015 discharges occurring on or after April 1, 2015, 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).

Effective October 1, 2014, through March 31, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges) during the fiscal year. For FY 2015 discharges occurring through March 31, 2015, the applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

For FY 2015 discharges occurring before April 1, 2015, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2014 update of the FY 2013 MedPAR file. Table 14 of the FY 2015 IPPS/LTCH PPS final rule (which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>) lists the “subsection (d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2014 update of the FY 2013 MedPAR file and their low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

Effective April 1, 2015, 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 2015 discharges occurring on or after April 1, 2015, the low-volume hospital adjustment for all qualifying hospitals is 25 percent. For FY 2015 discharges occurring on or after April 1, 2015, the MAC will make the discharge determination based on the hospital’s number of total discharges, that is, Medicare and non-Medicare discharges as reported on the hospital’s most recently submitted cost report. To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2015 discharges occurring on or after April 1, 2015, a hospital must be located more than 25 road miles (as defined at § 412.101(a)) from the nearest “ subsection (d) hospital” (that is, in general, an IPPS hospital).

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A hospital must notify and provide documentation to its 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 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 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.

To receive a low-volume hospital payment adjustment under 412.101, a hospital must notify and provide documentation to its MAC that it meets the discharge and distance requirements under 412.101(b)(2)(ii) for FY 2015 discharges occurring before April 1, 2015, and 412.101(b)(2)(i) for FY 2015 discharges occurring on or after April 1, 2015, if also applicable. Specifically, for FY 2015, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2014, in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges occurring on or after October 1, 2014, and through March 31, 2015, or through September 30, 2015, for hospitals that also meet the low-volume hospital payment adjustment qualifying criteria for discharges occurring during the second half of FY 2015.

A hospital that qualified for the low-volume payment adjustment in FY 2014 may continue to receive a low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015, without reapplying if it continues to meet the Medicare discharge criterion established for FY 2015 and the distance criterion. However, the hospital must send written verification that is received by its MAC no later than September 1, 2014, stating that it continues to be more than 15 miles from any other “subsection (d)” hospital. If a hospital’s written request for low-volume hospital status for FY 2015 is received after September 1, 2014, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2015 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

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, 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 the following Web site: 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 website.

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Electronic Health Record Incentive Program (EHR)

Section 1886(b) (3) (B) of the Social Security Act as amended by Section 4102(b) (1) of the Health Information Technology for Economic and Clinical Health (HITECH) Act requires CMS to apply a reduced annual payment update to the IPPS update for subsection(d) hospitals that are not meaningful EHR users or have not been granted a hardship exception. The statute also requires payment adjustments for eligible hospitals in states where hospitals are paid under Section 1814(b) (3) of the Act (waiver).

For FY2015, the applicable percentage increase to the IPPS payment rate is adjusted downward for those eligible hospitals that are not meaningful EHR users for the associated EHR reporting period for a payment year. This reduction applies to three-quarters of the percentage increase otherwise applicable. The reduction to three-quarters of the applicable update for an eligible hospital that is not a meaningful EHR user is 33 1/3 percent for FY 2015. In other words, for eligible hospitals that are not meaningful EHR users, the percentage increase is reduced for the entire FY by 25 percent (33 1/3 percent of 75 percent) in 2015.

A list of hospitals that will receive the EHR Incentive Payment reduction for FY 2015 is available in Attachment 1 in the Official Instruction to CR8900.

Hospital Acquired Conditions (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. 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. The HAC Reduction Program adjustment amount (that is, the 1-percent payment reduction) is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, new technology, readmissions, Value-Based Purchasing (VBP), low-volume hospital payments, and capital payments. This amount will be displayed in the PPS-FLX6- PAYMENT field in the IPPS PRICER output record. For SCHs and MDHs, the HAC Reduction Program adjustment amount applies to either the Federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

CMS did not make the list of providers subject to the HAC Reduction Program for FY 2015 public in the final rule because hospitals had until September 2014 to notify CMS of any errors in the calculation of their Total HAC Score under the Review and Correction period. Updated hospital level data for the Hospital-Acquired Condition (HAC) Reduction Program was made publicly available on December 18, 2014, in Table 17 at

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<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html> on the CMS website.

Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the VBP Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. CMS has continued to exclude Maryland hospitals from the Hospital VBP Program for the FY 2015 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (Sections 412.160 through 412.162).

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute. The applicable percent for payment reductions for FY 2015 is 1.50 percent. This percent is gradually increasing each fiscal year from 1.0 in FY 2013 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 calculates a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses 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 calculates a value-based incentive payment adjustment factor that is 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 2015 CMS will continue to 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 2015.

Table 16B of the FY 2015 IPPS/LTCH PPS final rule (which is available on the CMS website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>) contains the value-based incentive payment adjustment factors for FY 2015.

Table 16B data is used by the MACs to update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of 'Y' if the provider is included in the Hospital

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VBP Program and the Hospital VBP Program adjustment field (VBP Adjustment) to hold the value-based incentive payment adjustment factor for FY 2015.

Note: The values listed in Table 16A of the IPPS/LTCH PPS Final Rule are **proxy values**. These values are not used to adjust payments.

Hospital Readmissions Reduction Program

For FY 2015, the readmissions adjustment factor is the higher of a ratio or 0.97 (-3 percent). 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 (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor. However, the portion of a MDH's payment reduction due to excess readmissions that is based on 75 percent difference between payment under the hospital-specific rate and payment under the Federal rate will be determined at cost report settlement. In determining the claim payment, the PRICER will only apply the readmissions adjustment factor to a MDH's wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable) to determine the payment reduction due to excess readmissions.

Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2015 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. (Hospitals located in Puerto Rico are not subject to the Hospital Readmissions Reduction Program). For FY 2015, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

The Hospital Readmissions Reduction Program (HRRP) adjustment factors for FY 2015 are available in Table 15B of the FY 2015 IPPS final rule, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html> on the CMS website. Claims will be reprocessed if a hospital's HRR Adjustment factor changes when the actual factors are available in the near future. (Note: the values listed in Table 15A of the IPPS/LTCH PPS Final Rule are proxy values. These values are not used to adjust payments.)

Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, 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 this

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uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital's share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

The Medicare DSH payment will be 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 will be applied in PRICER.

For FY 2015, the total uncompensated care payment amount to be paid to Medicare DSH hospitals is \$7,647,644,885.18, as calculated as the product of 75 percent of Medicare DSH (estimated CMS Office of the Actuary) and the change in percent of uninsured individuals and an additional statutory adjustment at 76.19 percent. The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2015 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2015. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FYs 2011-2013).

The hospitals that were located in urban counties that are becoming rural under our adoption of the new OMB delineations, are subject to a transition for their Medicare DSH payment. For a hospital with more than 99 beds and less than 500 beds that was redesignated from urban to rural, it would be subject to a DSH payment adjustment cap of 12 percent. Under the transition, per the regulations at 412.102, for the first year after a hospital loses urban status, the hospital will receive an additional payment that equals two-thirds of the difference between DSH payment before its redesignation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its redesignation from urban to rural.

In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its redesignation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural. This adjustment will be determined at cost report settlement and will apply the DSH payment adjustment based on its urban/rural status according to the redesignation.

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

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report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

To review the “Provider Reimbursement Manual” - Part 1 visit <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html> on the CMS website.

LTCH PPS FY 2015 Update

FY 2015 LTCH PPS Rates and Factors are located in the final rule and are displayed below. The LTCH PPS Pricer has been updated with the Version 32.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2014, and on or before September 30, 2015.

Federal Rate for discharges from 10/1/14 through 09/30/15	Rates based on successful reporting of quality data. <ul style="list-style-type: none"> • Full update (quality indicator on PSF = 1): \$41,043.71 • Reduced update (quality indicator on PSF = 0 or blank): \$40,240.51
Labor Share	62.306 percent
Non Labor Share	37.694 percent
High Cost Outlier Fixed-Loss Amount	\$14,972

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. Beginning in FY 2015, the annual update to a standard Federal rate will 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.

Cost of Living Adjustment (COLA) Update for LTCH PPS

There are no changes to the COLAs for FY 2015, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2015 IPPS/LTCH PPS final rule and is also shown above in the table under **Cost of Living Adjustment (COLA) Update for IPPS PPS.**

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

CMS is updating the CBSA based labor market area definitions (and associated CBSA codes) used under the LTCH PPS for FY 2015. These revisions to the LTCH PPS geographic classifications are based on the most recent metropolitan statistical area (MSA) delineations issued by OMB using 2010 Census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS adopted a one-year transition for LTCHs that would experience a decrease in their wage index exclusively due to the implementation of the new OMB delineations. Under this transition policy, for discharges occurring in FY 2015, affected LTCHs will get a “50/50 blended area wage index” value that is calculated as the sum of 50 percent of the wage index computed under the FY 2014 CBSA designations (from Tables 12C and 12D, as applicable, of the FY 2015 IPPS/LTCH PPS final rule) and 50 percent of the wage index computed under the new OMB delineations for FY 2015 (from Tables 12A and 12B, as applicable, of the FY 2015 IPPS/LTCH PPS final rule).

Additional LTCH PPS Policy Changes for FY 2015

The statutory moratoria on the full implementation of the “25 percent threshold” payment adjustment originally put in place by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) is extended until the start of LTCH cost reporting periods beginning on either July or October, 2014, as applicable as provided by the Pathway for the Sustainable Growth Rate (SGR) Reform Act. The new extension generally maintained the same policies that have been in place, except that “grandfathered” LTCH hospitals-within-hospitals (HwH) are totally exempt from the application of the 25 percent threshold. For additional details, refer to the discussion in the FY 2015 IPPS/LTCH PPS final rule.

The FY 2015 IPPS/LTCH final rule also included the removal of the “5 percent” policy adjustment. Therefore, the policy specified at 42 CFR 412.532, Special Payment Provisions for Patients Who are Transferred to Onsite Providers and Readmitted to an LTCH, is no longer in effect beginning October 1, 2014.

Additional Information

The official instruction CR 8900 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3138CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

The following is a list of changes to CR 8900 that were made in the November 26, 2014 release:

- Renamed attachments and changed reference to attachments throughout policy section

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- Revised Table 1 for the corrected FY 2015 IPPS Rates and Factors in attachment 3, FY 2015 Rate Tables
- Corrected maximum new technology add-on payment for a case involving the Voraxaze
- Revised attachment 2, Special Wage Index CR8900
- Added information on updating the PSF for IPPS wage index, reclassifications and redesignations
- Included a new attachments for wage index redesignations and reclassifications
- Revised reference to Hospital Acquired Condition (HAC) Reduction Program data
- Revised reference to Table 16b, Hospital Inpatient Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2015
- Revised reference to corrected Table 15B, FY 2015 Readmissions Adjustment Factors
- Updated attachment 5, Uncompensated Care Payment Per Claim Amounts for Provider Specific File Revised CR8900
- Revised reference to corrected Table 8B, FY 2015 Statewide Average Capital Cost-To-Charge Ratios (CCRs) For Acute Care Hospitals-CN

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