CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3885	**Date: October 17, 2017**
	Change Request 10273

Transmittal 3858, dated September 8, 2017, is being rescinded and replaced by Transmittal 3885 dated, October 17, 2017 to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment. All other information remains the same.

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

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2018 update to the IPPS and LTCH PPS. This Recurring Update Notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3885	Date: October 17, 2017	Change Request: 10273

Transmittal 3858, dated September 8, 2017, is being rescinded and replaced by Transmittal 3885 dated, October 17, 2017 to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment. All other information remains the same.

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

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

I. GENERAL INFORMATION

A. Background: The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a Prospective Payment System (PPS) for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually. This Change Request (CR) outlines those changes for FY 2018.

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

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2017, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2017 through September 30, 2018. The new revised Pricer program shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

Files for download listed throughout the CR are available on the CMS website. Medicare Administrative Contractors (MACs) shall use the following links for files for download on the following pages (when not otherwise specified):

- FY 2018 Final Rule Tables webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html.

- FY 2018 Final Rule Data Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Data-Files.html.

- MAC Implementation Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-

MAC-Implementation.html.

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

IPPS FY 2018 Update

A. FY 2018 IPPS Rates and Factors

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

B. Medicare Severity -Diagnosis Release Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

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

For discharges occurring on or after October 1, 2017, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation in August 2017. A re-release of the GROUPER software, Version 35.0 R1 software package effective for discharges on or after October 1, 2017 was distributed in September 2017. An errata document accompanies this re-release detailing the updates made to the GROUPER software.

For discharges occurring on or after October 1, 2017, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should have received the MCE documentation in August 2017. Note that the MCE version continues to match the Grouper version. There were no updates made to the MCE in the re-release of the software package.

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

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

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

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

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

We revised the titles for MS-DRGs 823, 824 and 825 to Lymphoma and Non-Acute Leukemia with Other Procedure with MCC, with CC and without CC/MCC, respectively.

We revised the titles for MS-DRGs 829 and 830 to Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedure with CC/MCC and without CC/MCC, respectively.

C. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2018 have been evaluated against the general post-acute care transfer policy criteria using the FY 2016 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy; however MS-DRGs 987, 988 and 989 (Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis with MCC, with CC, without CC/MCC, respectively) were added to the special payment policy list:

See Table 5 of the FY 2018 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2018 Final Rule Tables webpage.

D. New Technology Add-On

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

1. Name of Approved New Technology:Defitelio®

- Maximum Add-onPayment:$75,900
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 orXW04392

2. Name of Approved New Technology: GORE IBE devicesystem

- Maximum Add-on Payment:$5,250
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC3EZ; 04VC4EZ; 04VD0EZ; 04VD3EZ or 04VD4EZ (we note ICD-10-PCS procedure codes 04VC0FZ; 04VC3FZ; 04VC4FZ; 04VD0FZ; 04VD3FZ; and 04VD4FZ are no longer valid effective October 1, 2017)

3. Name of Approved New Technology:Idarucizumab

- Maximum Add-on Payment:$1,750
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03331orXW04331

4. Name of Approved New Technology:Vistogard™

- Maximum Add-onPayment:$40,130 (Note: The maximum payment has changed from FY 2018)
- Identify and make new technology add-on payments with any of the following ICD-10-CM diagnosis codes T45.1x1A, T45.1x1D, T45.1x1S, T45.1x5A, T45.1x5D, or T45.1x5S in combination

with ICD-10-PCS procedure codeXW0DX82

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

5. Name of Approved New Technology: ZINPLAVA™

- Maximum Add-on Payment:$1,900
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes XW033A3 or XW043A3.

6. Name of Approved New Technology: Stelara®

- Maximum Add-on Payment: $2,400
- Identify and make new technology add-on payments with ICD-10-PCS procedure code XW033F3.

7. Name of Approved New Technology: EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)

- Maximum Add-on Payment: $6,110.23
- Identify and make new technology add-on payments with ICD-10-PCS code X2RF032.

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

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

F. FY 2017 Wage Index Changes and Issues

1. Transitional Wage Indexes

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

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

2. Adoption of FIPS County Codes

CBSAs are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and Federal Information Processing Standard (FIPS) codes. Historically, CMS has listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the hospital wage index. We have learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census

Bureau's most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For the purposes of crosswalking counties to CBSAs, in the FY 2018 IPPS/LTCH PPS final rule, we finalized to discontinue the use of SSA county codes and begin using only the FIPS county codes beginning in FY 2018.

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

- Petersburg Borough, AK (FIPS State County Code 02-195), CBSA 02, was created from part of former Petersburg Census Area (02-195) and part of Hoonah-Angoon Census Area (02-105).The CBSA code remains 02.

- The name of La Salle Parish, LA (FIPS State County Code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22-059).The CBSA code remains as 14.

- The name of Shannon County, SD (FIPS State County Code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46-102).The CBSA code remains as 43.

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

Note: The county update changes listed above changed the county names. However, the CBSAs to which these counties map did not change from the prior counties. Therefore, there is no payment impact or change to hospitals in these counties; they continue to be considered rural for the hospital wage index under these changes. Also, these new FIPS county codes above were included in the instructions and files to MACs in July 2017 to fill in the County Code (data element 60) field in the Provider Specific File (PSF).

3. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. The following is a list of hospitals that have waived Lugar status for FY 2018: 010164, 070004, 070011, 140167, 250117, 390008, 390031, 390150 and 520102. Complete details on how to fill out the PSF for these hospitals are provided in Attachment 1 of this CR.

4. Section 505 Hospital (Out-Commuting Adjustment)

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

Prior to FY 2018, in order to include the out migration in a hospital's wage index, MACs inserted a "1" in the Special Payment Indicator (data element 33) field, and inserted the wage index value in the Special Wage Index field (data element 38). For FY 2018, Pricer will assign the out migration adjustment using the County Code (data element 60) field in the PSF. **For FY 2018, MACs will no longer need to insert a "1" to data element 33 and the wage index value in data element 38.** Therefore, MACs shall ensure that every hospital has listed in data element 60 the FIPS county code where the hospital is located. Complete instructions to fill out the PSF for the wage index are in Attachment 1 of this CR.

G. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals reclassified under the Medicare Geographic Classification Review Board (MGCRB)

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

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

For FY 2018, we have created new mechanisms in the PSF to recognize and pay hospitals that have simultaneous reclassifications. The instructions in Attachment 1 of this CR reflect the changes to correctly populate the PSF in this circumstance.

H. Multicampus Hospitals with Inpatient Campuses in Different CBSAs

Beginning with the FY 2008 wage index, we instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CCN of the hospital in the PSF, to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also, note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF, (see Attachment 1 of this CR for how to update the PSF). In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers. In addition, if MACs learn of additional mergers during FY 2018 in which a multicampus hospital with inpatient campuses located in different CBSAs is created, please contact Miechal.Kriger@cms.hhs.gov and Michael.Treitel@cms.hhs.gov for instructions.

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

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

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

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

Provider Types 14 and 15 will no longer be valid beginning October 1, 2017.

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

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

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

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

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

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

For FY 2018 discharges occurring on or after October 1, 2017, the Pricer will apply the low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF.

If a hospital qualified for the low-volume hospital payment adjustment for FY 2017, but no longer meets the low-volume hospital definition for FY 2018, and therefore, the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective October 1, 2017, the MAC must update the low-volume indicator field on the PSF (position 74 - temporary relief indicator) to hold a value of 'blank'. (Most of the hospitals that qualified for the low-volume hospital payment adjustment for FY 2017 will no longer be eligible to receive a low-volume hospital payment adjustment for FY 2018, and the low-volume indicator field and the applicable adjustment factor on the PSF should be updated to hold a value of 'blank' effective October 1, 2017.)

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

hospital payment adjustment verify that they meet both the mileage criterion and the discharge criterion applicable for FY 2018 to continue receiving the adjustment for FY 2018.

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

M. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following Web site: www.qualitynet.org. A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) for each hospital that will receive the quality initiative bonus. The field shall be left blank for hospitals that will receive the statutory reduction under the Hospital Inpatient Quality Reporting (IQR) Program. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site, and MACs shall update the provider file as needed. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2018 under the Hospital IQR Program are found in MAC Implementation File 3 available on the FY 2018 MAC Implementation Files webpage.

For new hospitals, A/B MACs shall enter a ‘1’ in the PSF and provide information to the Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Support Contractor (SC) as soon as possible so that the Hospital Inpatient VIQR SC can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the Hospital Inpatient VIQR SC the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital IQR Program reporting requirements. The MACs shall provide this information monthly to the Hospital Inpatient VIQR SC. It shall include: State Code, Medicare Accept Date, Provider Name, Contact Name and email address (if available), Provider ID number, physical address, and Telephone Number.

N. Hospital Acquired Condition Reduction Program (HAC)

Under the Hospital Acquired Conditions (HAC) Reduction Program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year.

A list of providers subject to the HAC Reduction Program for FY 2018 was not publicly available in the final rule because the review and correction process was not yet completed. MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program in a Technical Direction Letter (TDL). Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

Until CMS issues final values, contractors shall enter ‘N’ in the HAC Reduction Indicator field.

O. Hospital Value Based Purchasing (VBP)

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

Upon receipt of this file, the MACs must update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of 'Y' if the provider is included in the Hospital VBP Program and the claims processing contractors must update the Hospital VBP Program adjustment field (VBP Adjustment) to input the value-based incentive payment adjustment factor. Note that the values listed in Table 16A of the FY 2018 IPPS/LTCH PPS Final Rule are proxy values. These values are not to be used to adjust payments.

Until CMS issues final values, contractors shall enter 'N' in the VBP Participant field.

P. Hospital Readmissions Reduction Program

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

The Hospital Readmissions Reduction Program participant (HRR Participant) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF must be updated by the MAC with an effective date of October 1, 2017.

- If a provider has a readmissions adjustment factor on Table 15, MACs shall input a value of '1'in the HRR Participant field and enter the readmissions adjustment factor in the HRR Adjustment field.

- If a provider is not listed on Table 15, MACs shall input a value of '0' in the HRR Participant field and leave the HRR Adjustment field blank.

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

Q. Medicare Disproportionate Share Hospitals (DSH) Program

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

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

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2018 IPPS Final Rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2018. The Uncompensated Care Per Discharge Amount and Projected DSH Eligibility are located in the Medicare DSH Supplemental Data File for FY 2018, which are available through the Internet on the FY 2018 Final Rule Data Files webpage.

MACs shall enter the updated estimated per discharge uncompensated care payment amounts in data element 57 in the PSF from the FY 2018 IPPS Final Rule: Medicare DSH Supplemental Data File, as described below. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition, the estimated per discharge uncompensated care payment amount will be included as a Federal payment for Sole Community Hospitals to determine if a claim is paid under the hospital-specific rate or Federal rate (and for Medicare Dependent Hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the Federal rate, when applicable). The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

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

If a new hospital has a CCR on line 1 of Worksheet S-10 in excess of 0.932, please contact Section3133DSH@cms.hhs.gov for further instructions on how to calculate the uncompensated care costs for the numerator.

R. Recalled Devices

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

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

LTCH PPS FY 2018 Update

A. FY 2018 LTCH PPS Rates and Factors

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

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

1. Application of the Site Neutral Payment Rate

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

The application of the site neutral payment rate is codified in the regulations at § 412.522 (80 FR 49601-49623). Section 15009 of the 21st Century Cures Act establishes a temporary exception to the application of the site neutral payment rate for certain spinal cord specialty hospitals, effective for discharges occurring during such LTCHs' cost reporting periods beginning during FY 2018 and FY 2019. Section 15010 of the 21st Century Cures Act establishes a temporary exception to the site neutral payment rate for certain severe wound discharges from certain LTCHs for cost reporting periods beginning during FY 2018. Information on the requirements implementing these temporary exceptions can be found in CRs 10182 and 10185, respectively. However this instruction includes a business requirement for MACs to prepare the Provider Specific File for the new policy to be implemented as set forth in those CRs.

The provisions of section 1206(a) of Public Law 113-67 establishes a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which is implemented in the regulations at § 412.522(c)(1). The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted. This transitional blended payment rate for site neutral payment rate LTCH discharges is included in the Pricer logic, and MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.

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

B. Changes to the Short-Stay Outlier (SSO) Payment Adjustment

We are revising the payment formula used to determine payments for Short Stay Outlier (SSO) cases beginning in FY 2018. This change is reflected in the LTCH PPS Pricer logic.

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

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

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

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

D. LTCH Quality Reporting (LTCHQR) Program

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

E. Provider Specific File (PSF)

The PSF required fields for all provider types, which require a PSF can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each LTCH as needed, and update all applicable fields for LTCHs effective October 1, 2017, or effective with cost reporting periods that begin on or after October 1, 2017, or upon receipt of an as-filed (tentatively) settled cost report.

As noted above in section A.1., effective with discharges occurring in LTCHs' **cost reporting periods beginning on or after October 1, 2017** (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based on 100 percent of the site neutral payment rate for the discharge. **MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.**

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

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital' s provider agreement in accordance with 42 CFR section 489.18).

2. LTCHs with a total CCR is in excess of 1.280 (referred to as the total CCR ceiling).

3. Any hospital for which data to calculate a CCR is notavailable.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

F. Cost of Living Adjustment (COLA) under the LTCHPPS

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

G. 25-percent Threshold Policy

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

H. Average Length of Stay Calculation

Section 15007 of the 21st Century Cures Act excluded Medicare Advantage and site neutral discharges from the calculation of the average length of stay for all LTCHs. CMS codified changes to the regulations at §

412.23(e)(3) in the FY 2018 final rule.

I. Discharge Payment Percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon final settlement of the cost report. MACs may use the form letter available on the Internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html to notify LTCHs of their discharge payment percentage.

J. Extended Neoplastic Disease Care Hospitals

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

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

Hospitals Excluded from the IPPS

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

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10273.1	Medicare contractor shall install and pay claims with the FY 2018 IPPS Pricer for discharges on or after October 1, 2017.					X				
10273.2	Medicare contractor shall install and pay claims with the FY 2018 LTCH Pricer for discharges on or after October 1, 2017.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10273.3	Medicare contractor shall install and edit claims with the MCE version 35.0 and Grouper version 35.0 software with the implementation of the FY 2018 October quarterly release.					X				
10273.4	Medicare contractor shall establish yearly recurring hours to allow for updates to the list of ICD-10-CM diagnosis codes that are exempt from reporting Present on Admission (POA). **NOTE:** The list of ICD-10-CM diagnosis codes exempt from reporting POA are displayed on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html.					X				
10273.5	Medicare contractors shall inform the Quality Improvement Organization (QIO) of any new hospital that has opened for hospital quality purposes.	X								
10273.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 9, 2017.	X								
10273.6.1	Medicare contractors shall follow the instructions in the policy section and Attachment 1 of this CR to update the PSF and ensure that the CBSA is assigned properly for all IPPS providers. **NOTE**: MACs must follow these instructions for the following: All current IPPS hospitals; any new hospitals that open during FY 2018; or any change of hospital status during FY 2018.	X								
10273.7	Medicare contractors shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.	X								
10273.7.1	For hospitals paid under the IPPS, Medicare contractors shall remove the 'Y' low-volume indicator in the PSF (position 74 - temporary relief indicator) for providers who no longer qualify as a low volume provider.	X								
10273.8	Medicare contractors shall be aware of any manual	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	updates included within this CR.									
10273.9	The CWF shall update edit and IUR 7272 as necessary for the post acute DRGs listed in Table 5 of the IPPS Final Rule when changes are made. **NOTE**: There are no changes to the post acute DRGs listed in Table 5 in the FY 2018 IPPS Final Rule. However, MS-DRGs 987, 988 and 989 have been added to the special payment policy list.								X	
10273.10	For each LTCH's cost reporting period beginning on or after October 1, 2017, contractors shall determine the LTCH's discharge payment percentage by dividing the number of LTCH PPS standard Federal payment rate discharges by the total number of LTCH PPS discharges.	X								
10273.10.1	For each LTCH's cost reporting period beginning on or after October 1, 2017, at settlement of such cost reporting period contractors shall inform LTCHs in writing of their discharge payment percentage. An example letter for informing an LTCH of its discharge payment percentage can be found on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html	X								
10273.11	For providers paid under the IPPS or LTCH PPS located in counties listed in MAC Implementation File 1 (as described in the policy section of this CR), MACs shall update the COLA with the value listed in the column for FY 2018.	X								
10273.12	Effective for discharges on or after October 1, 2017, Pricer will apply the out migration adjustment. Therefore, for all IPPS providers, MACs shall ensure that no hospital has a "1" or "2" in the Special Payment Indicator (data element 33) field and no wage index value in the Special Wage Index field (data element 38) with an effective date of October 1, 2017.	X								
10273.13	Effective October 1, 2017, unless otherwise instructed by CMS, MACs shall seek approval from the CMS central office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	element 38).									
10273.14	Medicare contractors shall set Provider Specific File, data element 17, file position 74, Temporary Relief Indicator to blank by removing any 'Y' values for LTCH providers (XX2000-XX2299) in order to prepare the Provider Specific File for new policy effective October 1, 2017, to be implemented January 2, 2018, in CRs 10182 and 10185.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10273.15	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@cms.hhs.gov , Jason Kerr, jason.kerr@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Attachment 1

MACs shall update the PSF by following the steps **in the order listed below to ensure the appropriate wage index is assigned properly** based on policies mentioned in this CR. **We note, as MACs follow the steps in the sequence below, they may overwrite values filled in from a previous step.**

Files for download listed throughout the CR are available on the CMS website. MACs shall use the following links for files for download on the following pages (when not otherwise specified):

- **FY 2018 Final Rule Tables Webpage:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html.
- **FY 2018 Final Rule Data Files Webpage:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Data-Files.html.
- **MAC Implementation Files Webpage:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html.

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

Note: Unless otherwise instructed, MACs shall use the final rule or if applicable correction notice version of the tables and data files posted on the FY 2018 Final Rule Tables and FY 2018 Final Rule Data Files webpages. Information on revisions made to the applicable correction notice tables and data files can be found on the MAC Implementation Files Webpage.

Section 1: Hospitals Listed on FY 2018 Final Rule Table 2

Step 1- **STATE CODE, GEOGRAPHIC CBSA and COUNTY CODE:** Ensure the following fields are filled out for all providers with the correct value:

- Data element 19 contains the two digit state code. This field should match the first state code listed for each state on Publication 100-07, State Operations Manual, Chapter 2, Section 2779A1. This manual is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf.
- The Actual Geographic Location Core-Based Statistical Area (CBSA) field in the PSF (data element 35) contains either a two digit state code or a 5 digit CBSA code (depending if the hospital is physically located in an urban or rural area). This field should match the value in the "Geographic CBSA" column on FY 2018 Final Rule Table 2.

- If not already filled in per business requirement 9926.2 of change request 9926, fill in the FIPS county code in the county code field (data element 60). This field should match the value on the "FIPS County Code" column on FY 2018 Final Rule Table 2. *Note: Do not use the value in the "SSA County Code" column.*

Step 1a- **Hold Harmless Transition Wage Indexes**: For provider numbers 010051, 130067, 170074, 250036, 330008, 330386, 370084 and 460057, remove the "1" in the Special Payment Indicator (data element 33) field and remove the wage index value in the Special Wage Index field (data element 38) with an effective date of October 1, 2017.

Step 1b- **Removal of Special Pay Wage Indexes**: Effective for discharges on or after October 1, 2017, Pricer will apply the out migration adjustment. Therefore, for all IPPS providers, MACs shall ensure that no hospital has a "1" or "2" in the Special Payment Indicator (data element 33) field and no wage index value in the Special Wage Index field (data element 38) with an effective date of October 1, 2017.

Effective October 1, 2017, unless otherwise instructed by CMS, MACs must seek approval from the CMS central office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).

Step 1c- **Indian Health Providers**: Pricer will apply the applicable wage index for Indian Health Service (IHS) or Tribal hospitals if the Provider Type Field (data element 9) is a "08". MACs shall ensure that data element 9 is a "08" for IHS or Tribal hospitals and follow the rest of the steps below in this section.

Step 2- **LUGAR Hospitals**

a) The following hospitals have waived LUGAR status for FY 2018 and are deemed rural for all payments: 010164, 070004, 070011, 140167, 250117, 390008, 390031, 390150 and 520102. For these hospitals, ensure the following:
    - Data element 35 reflects the CBSA of the hospital's geographic rural location. This field should match the value in the "Geographic CBSA" column on FY 2018 Final Rule Table 2.
    - Data elements 33, 36, and/or 37 shall contain "blank" values with an effective date of October 1, 2017.

Note: These hospitals above are now eligible for the out migration adjustment (as described in the note below in this section).

b) For hospitals that are an active urban to rural 412.103 reclassification as of October 1, 2017 and the following is displayed on FY 2018 Final Rule Table 2: a "X" in the "Dual Status 412.103 and MGCRB/LUGAR" column; and have the word "LUGAR" or "NECMA" in the "Lugar/NECMA" column, MACs shall do the following:
    - Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date of October 1, 2017.

- Enter a "Y" for reclassified in the Special Payment Indicator field (data element 33)
- Enter the CBSA from the Reclassified/Redesignated column on FY 2018 Final Rule Table 2 in the Wage Index Location CBSA field (data element 36)
- Ensure that data element 38 is blank

Note: *Under this scenario (2(b)), MACs shall ensure that hospitals located in a LUGAR county, have an active urban to rural 412.103 reclassification as of October 1, 2017 and did not waive its LUGAR status (see step 2(a) for a list of hospitals that waived LUGAR status) are reflected in the PSF per the instruction above.*

c) For hospitals that have the following on FY 2018 Final Rule Table 2: the word "LUGAR" or "NECMA" in the "Lugar/NECMA" column, do **not** have a "Y" in the "MGCRB Reclass" column, and have a blank in the "Dual Status 412.103 and MGCRB/LUGAR" column, MACs shall do the following:
   - Ensure the two digit rural CBSA state code from the "Geographic CBSA" column (FY 2018 Final Rule Table 2) is in the Geographic Location Core-Based Statistical Area (CBSA) field in the PSF (data element 35) with an effective date of October 1, 2017. (This two digit rural CBSA code is the same as the state code in data element 19.)
   - Enter a "Y" for reclassified in the Special Payment Indicator field (data element 33)
   - Enter the CBSA from the Reclassified/Redesignated column in FY 2018 Final Rule Table 2 in the Wage Index Location CBSA field (data element 36) and in the Standardized Amount CBSA field (data element 37) with an effective date of October 1, 2017.

d) For hospitals that have the following on FY 2018 Final Rule Table 2: the word "LUGAR" or "NECMA" in the "Lugar/NECMA" column, **have** a "Y" in the "MGCRB Reclass" column, and have a blank in the "Dual Status 412.103 and MGCRB/LUGAR" column, MACs shall do the following:
   - Ensure the two digit state code from data element 19 matches the Geographic Location Core-Based Statistical Area (CBSA) field in the PSF (data element 35) with an effective date of October 1, 2017.
   - Enter a "Y" for reclassified in the Special Payment Indicator field (data element 33)
   - Enter the CBSA from the Reclassified/Redesignated column on FY 2018 Final Rule Table 2 in the Wage Index Location CBSA field (data element 36)
   - Match the "County Code" in the FIPS County Code column on FY 2018 Final Rule Table 2 to the FIPS County code on MAC Implementation File 4 and enter the urban CBSA on MAC Implementation File 4 from the column titled "LUGAR CBSA" in the Standardized Amount CBSA field (data element 37)

Step 3- **Urban to Rural Reclassification (42 CFR 412.103)**:

For hospitals that are an active urban to rural 412.103 reclassification as of October 1, 2017 and the following is displayed on FY 2018 Final Rule Table 2: a "Y" in the "Hospital Reclassified as Rural Under Section 1886(d)(8)(E) of the Act (412.103)" column, a blank in the "Dual Status 412.103 and MGCRB/LUGAR" column, MACs shall do the following:

- Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date of October 1, 2017.
- Ensure that data elements 33, 36, and 38 are blank.

Note: FY 2018 Final Rule Table 2 contains a hospital's urban to rural 412.103 reclassification status as of the time of the development of the FY 2018 final rule. A hospital may have been approved or may have cancelled urban to rural 412.103 reclassification after this time and before October 1, 2017; thus, a hospital's urban to rural 412.103 reclassification status at the time of the effective date of this change request may not be reflected in FY 2018 Final Rule Table 2. Therefore, MACs shall ensure that any changes in urban to rural 412.103 reclassification status are reflected in the PSF so hospitals are paid appropriately for periods prior to and after October 1, 2017. To update the PSF, follow the instructions in Section 3 (titled "Hospitals Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year") below, if the hospital was approved for an urban to rural 412.103 reclassification, and follow the instructions in Section 4 (titled "Hospitals that Cancel their Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year") below, if the hospital cancelled its urban to rural 412.103 reclassification. As discussed in these sections, it may be necessary for the MAC to reprocess claims from the effective date in the PSF until the date of reprocessing to ensure that claims are paid correctly.

Note: For hospitals that are subsequently approved for urban to rural 412.103 reclassification with an effective date after 10/1/2017, see Section 3 (titled "Hospitals Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year") below. Also, for hospitals that subsequently cancel an approved urban to rural 412.103 reclassification with an effective date after 10/1/2017, see Section 4 (titled "Hospitals that Cancel their Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year") below.

Step 4- **MGCRB Reclassification**:

a) For hospitals that are an active urban to rural 412.103 reclassification as of October 1, 2017, and the following is displayed on FY 2018 Final Rule Table 2: an "X" in the "Dual Status 412.103 and MGCRB/LUGAR" column; a "Y" in the "MGCRB Reclass" column; the CBSA in the "Geographic CBSA" column **matches** the CBSA in the "Reclassified/Redesignated CBSA column", MACs shall do the following:
   - Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date of October 1, 2017.
   - Enter a "D" for reclassified in the Special Payment Indicator field (data element 33)
   - Enter the CBSA from the Reclassified/Redesignated column on FY 2018 Final Rule Table 2 in the Wage Index Location CBSA field (data element 36)

Note: *Under this scenario (4(a)), MACs shall ensure that hospitals with dual status have an active urban to rural 412.103 reclassification as of October 1, 2017.*

b) For hospitals that are an active urban to rural 412.103 reclassification as of October 1, 2017 and the following is displayed on FY 2018 Final Rule Table 2: an "X" in the "Dual Status 412.103 and MGCRB/LUGAR" column; a "Y" in the "MGCRB Reclass" column , the "Lugar/NECMA" column is blank, the CBSA in the "Geographic CBSA" column **differs** from the CBSA in the "Reclassified/Redesignated CBSA column", MACs shall do the following:
   - Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date of October 1, 2017.
   - Enter a "Y" for reclassified in the Special Payment Indicator field (data element 33)
   - Enter the CBSA from the Reclassified/Redesignated column on FY 2018 Final Rule Table 2 in the Wage Index Location CBSA field (data element 36)
   - Ensure that data element 38 is blank

Note: *Under this scenario (4(b)), MACs shall ensure that hospitals with dual status have an active urban to rural 412.103 reclassification as of October 1, 2017.*

c) For hospitals that have the following on FY 2018 Final Rule Table 2: a "Y" in the "MGCRB Reclass" column (and do not have a "X" in the "Dual Status 412.103 and MGCRB/LUGAR" column and do not have the word "LUGAR" or "NECMA" in the "Lugar/NECMA" column), MACs shall do the following:
   - Enter a "Y" for reclassified in the Special Payment Indicator field (data element 33)
   - Enter the reclassified CBSA from the column titled ""Reclassified/Redesignated CBSA" on FY 2018 Final Rule Table 2 in the Wage Index Location CBSA field (data element 36) with an effective date of October 1, 2017.
   - Ensure that data elements 37 and 38 are blank.

<u>Step 5:</u>

(a) If a hospital is located in a LUGAR county or qualified for reclassification (MGCRB and/or urban to rural 412.103) in FY 2017, MACs must verify that the hospital's LUGAR status or reclassification carries over to FY 2018. MACs shall ensure that all hospitals that are located in a LUGAR county or qualified for reclassification in FY 2017 continue to maintain such status by following steps 1-4 above.

(b) If a hospital no longer has the word "LUGAR" or "NECMA" in the "Lugar/NECMA" column on FY 2018 Final Rule Table 2, or no longer has a "Y" in the "MGCRB Reclass" column on FY 2018 Final Rule Table 2 for FY 2018, MACs shall delete the reclassified CBSA from data elements 36 and/or 37 and insert "blank" in data element 33 with an effective date of October 1, 2017.

NOTE: Out Migration Adjustment: *Effective for discharges on or after October 1, 2017, Pricer will apply the out migration adjustment. Hospitals that are LUGAR (and did not waive their LUGAR status) or qualify for MGCRB or urban to rural 412.103 reclassification are not eligible for the out migration adjustment. Therefore, if the MAC has entered a "Y" in the Special Payment Indicator field (data element 33) from step 2, 3 or 4 or has entered the rural CBSA in data element 37, then the hospital does not qualify for the out migration adjustment.*

Section 2: Hospitals Not Listed on FY 2018 Final Rule Table 2 and New Hospitals in FY 2018

Note: Only hospitals listed on FY 2018 Final Rule Table 2 *are typically eligible for MGCRB reclassification. Therefore, this section does not address MGCRB reclassification.*

Step 1- **STATE CODE:** Ensure the state code in data element 19 is filled out. This field should match the first state code listed for each state on Publication 100-07, State Operations Manual, Chapter 2, Section 2779A1. This manual is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf.

Step 1a- **Special Pay Wage Indexes**: Effective for discharges on or after October 1, 2017, Pricer will apply the out migration adjustment. Therefore, for all IPPS providers, MACs shall ensure that no hospital has a “1” or “2” in the Special Payment Indicator (data element 33) field and no wage index value in the Special Wage Index field (data element 38) with an effective date of October 1, 2017.

Effective October 1, 2017, unless otherwise instructed by CMS, MACs must seek approval from the CMS central office to use a “1” or “2” in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).

Step 1b- **Indian Health Providers**: Pricer will apply the applicable wage index for Indian Health Service (IHS) or Tribal hospitals if the Provider Type Field (data element 9) is a “08”. MACs shall ensure that data element 9 is a “08” for IHS or Tribal hospitals and follow the rest of the steps below in this section.

Step 2a- **County Code:** Per business requirement 9926.2 of change request 9926, fill in the FIPS county code in the county code field (data element 60). MACs shall determine the county where the provider is located and fill in the appropriate FIPS county code in the “FIPS County Code” column from the *County to CBSA Crosswalk* file on the FY 2018 Final Rule Data Files webpage. ***Note: Do NOT use the code in the column titled “SSACD”.***

Step 2b- **Geographic Location**: MACs shall ensure the Actual Geographic Location Core-Based Statistical Area (CBSA) field in the PSF (data element 35) reflects the correct current CBSA delineations. Use the *County to CBSA Crosswalk* file on the on the FY 2018 Final Rule Data Files webpage. Determine the county that the hospital is located in and insert in data element 35 the CBSA code from the column titled “CBSA”. If the CBSA column is blank, then the hospital is rural so insert the two digit state code from data element 19 into data element 35.

Step 3- **LUGAR Hospitals**:

a) For hospitals located in rural counties that are deemed Lugar counties on MAC Implementation File 4 and are not approved for an urban to rural 412.103 reclassification, MACs shall do the following:
   - Enter a "Y" for reclassified in the Special Payment Indicator field (data element 33)
   - Enter the urban CBSA on MAC Implementation File 4 from the column titled "LUGAR CBSA" in the Wage Index Location CBSA field (data element 36) *and* in the Standardized Amount CBSA field (data element 37) with an effective date of October 1, 2017.

Note: Only those counties listed on MAC Implementation File 4 are deemed Lugar for FY 2018.

b) For hospitals located in rural counties that are deemed Lugar counties on MAC Implementation File 4 and have been approved by the CMS regional office to reclassify as rural under section 1886(d)(8)(E) of the Act (42 CFR 412.103), MACs shall do the following:
   - Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date of October 1, 2017 or effective the date that the CMS Regional Office received the hospital's application (typically specified in the Regional Office's approval letter)..
   - Enter a "Y" for reclassified in the Special Payment Indicator field (data element 33).
   - Enter the urban CBSA on MAC Implementation File 4 from the column titled "LUGAR CBSA" in the Wage Index Location CBSA field (data element 36)
   - Ensure that data element 38 is blank.

Note: Only those counties listed on MAC Implementation File 4 *are deemed Lugar for FY 2018.*

Step 4- **Urban to Rural Reclassification (42 CFR 412.103)**:

If a hospital is located in an urban CBSA and has been approved by the CMS Regional Office to reclassify as rural under section 1886(d)(8)(E) of the Act (42 CFR 412.103) (and the hospital is not located in a LUGAR county on MAC Implementation File 4 and does not have a MGCRB reclassification), MACs shall do the following:

- Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date in the PSF that is the date that the CMS Regional Office received the hospital's application (typically specified in the Regional Office's approval letter).
- MACs shall ensure that data elements 33, 36, and 38 are blank.
- Ensure that all claims after the effective date in the PSF are paid correctly; the MAC may need to apply different wage indexes for portions of the Federal fiscal year, and may need to reprocess claims from the effective date in the PSF until the date of reprocessing to ensure that claims are paid correctly.

Note: For hospitals that are subsequently approved for urban to rural 412.103 reclassification with an effective date after 10/1/2017, see section 3 (titled "Hospitals Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year") below. Also, for hospitals that subsequently cancel an approved urban to rural 412.103 reclassification with an effective date after 10/1/2017, see Section 4 (titled "Hospitals that Cancel their Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year") below.

Step 5: If a hospital is located in a LUGAR county or qualified for reclassification (MGCRB and/or urban to rural 412.103) in FY 2017, MACs must verify that the hospital's LUGAR status or reclassification carries over to FY 2018. MACs shall ensure that all hospitals that are located in a LUGAR county or qualified for reclassification in FY 2017 continue to maintain such status by following steps 1-4 above. If a hospital no longer has LUGAR status or no longer qualifies for reclassification for FY 2018, MACs shall delete the reclassified CBSA from data elements 36 and/or 37 and insert "blank" in data element 33 and 38.

NOTE: Out-Migration Adjustment: *Effective for discharges on or after October 1, 2017, Pricer will apply the out migration adjustment. Hospitals that are LUGAR (and did not waive their LUGAR status) or qualify for MGCRB or urban to rural 412.103 reclassification are not eligible for the out migration adjustment. Therefore, if the MAC has entered a "Y" in the Special Payment Indicator field (data element 33) from step 3 or 4 or has entered the rural CBSA in data element 37, then the hospital cannot qualify for the outmigration adjustment.*

Section 3: Hospitals Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year

At any point during a fiscal year, MACs may be notified by the CMS Regional Offices of hospitals located in an urban CBSA that are approved to reclassify as rural under section 1886(d)(8)(E) of the Act (42 CFR 412.103). The regulations at 412.103(a)(c) provide the CMS Regional Offices with up to 60 days to review and approve an urban to rural 412.103 reclassification request.

a) Effective April 21, 2016, hospitals nationwide that have an MGCRB reclassification or LUGAR status (during FY 2016 and subsequent fiscal years) and are then subsequently approved by the CMS Regional Office to reclassify as rural under section 1886(d)(8)(E) of the Act (42 CFR 412.103) may keep their existing LUGAR status or MGCRB reclassification for purposes of payment under the wage index. Under this scenario, MACs shall do the following:
    a) Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date in the PSF that is the date that the CMS Regional Office received the hospital's application (typically specified in the Regional Office's approval letter).
    b) Enter (or leave in place) a "Y" or "D" for reclassified in the Special Payment Indicator field (data element 33).

c) Enter (or leave in place) the MGCRB or LUGAR CBSA in the Wage Index Location CBSA field (data element 36)
d) Ensure that data element 38 is blank.
e) Ensure that all claims after the effective date in the PSF are paid correctly. We note, if the MAC made no changes to data elements 33 and 36 and therefore no changes were made to the wage index, an urban to rural 412.103 reclassification still affects other payment policies such as Medicare Disproportionate Share (DSH). Therefore, if necessary, the MAC may still need to reprocess claims from the effective date in the PSF until the date of reprocessing to ensure that claims are paid correctly.

b) If the hospital is approved by the CMS Regional Office to reclassify as rural under section 1886(d)(8)(E) of the Act (42 CFR 412.103) **and does not** have an existing LUGAR status or MGCRB reclassification, MACs shall do the following:
   - Enter the two digit state code from data element 19 in the Standardized Amount CBSA field (data element 37) with an effective date in the PSF that is the date that the CMS Regional Office received the hospital's application (typically specified in the Regional Office's approval letter).
   - Ensure that data elements 33, 36, and 38 are blank.
   - Ensure that all claims after the effective date in the PSF are paid correctly; if necessary, the MAC may need to reprocess claims from the effective date in the PSF until the date of reprocessing to ensure that claims are paid correctly.

Section 4: Hospitals that Cancel their Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (42 CFR 412.103) in the Middle of the Fiscal Year

If a hospital notifies the CMS Regional Office that it wishes to cancel its urban to rural reclassification under section 1886(d)(8)(E) of the Act (42 CFR 412.103), MACs shall do the following:

a) Delete the rural CBSA from Standardized Amount CBSA field (data element 37) effective with the beginning of the hospital's next full cost reporting period (or if the hospital is a Rural Referral Center, effective with the beginning of the Federal fiscal year following the 12-month cost reporting period in which it was paid as rural). The effective date of this change must follow the rules of section 412.103(g).

b) If the hospital is listed on FY 2018 Final Rule Table 2, follow steps 1, 1a, 1b, 1c, 2(c), 2(d), 4(a), 4(c), and 5 in Section 1 above (titled "Hospitals Listed on FY 2018 Final Rule Table 2") with the following exceptions:
   - For steps 2(c) and 2(d), disregard the requirement that hospitals must have a blank in the "Dual Status 412.103 and MGCRB/LUGAR" column);
   - For step 4(a) disregard the requirement for an "X" in the "Dual Status 412.103 and MGCRB/LUGAR" column;
   - For step 4(c), disregard the requirement that hospitals do not have a "X" in the "Dual Status 412.103 and MGCRB/LUGAR" column).

Note: *Per the steps required of this bullet, if the hospital has LUGAR status or is approved for reclassification by the MGCRB, leave in place the following: the MGCRB or LUGAR CBSA in the Wage Index Location CBSA field (data element 36) and the "Y" or "D" for reclassified in the Special Payment Indicator field (data element 33).*

c) If the hospital is not listed on FY 2018 Final Rule Table 2, follow steps 1, 1a, 1b, 2a, 2b, 3, and 5 (skip step 4) in section 2 above (titled "Hospitals Not Listed on FY 2018 Final Rule Table 2 and New Hospitals in FY 2018").

Note: *Per the steps required of this bullet, if the hospital has LUGAR status or is approved for reclassification by the MGCRB, leave in place the following: the MGCRB or LUGAR CBSA in the Wage Index Location CBSA field (data element 36) and the "Y" for reclassified in the Special Payment Indicator field (data element 33).*

d) Ensure claims are paid correctly. It may be necessary for the MAC to reprocess claims from the effective date in the PSF until the date of reprocessing to ensure that claims are paid correctly.