CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12234	**Date: August 31, 2023**
	Change Request 13306

SUBJECT: Fiscal Year (FY) 2024 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: The purpose of this recurring Change Request (CR) is to provide the FY 2024 update to the IPPS and LTCH PPS. This Recurring Update Notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2023

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
R	3/Addendum A - Provider Specific File

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

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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 2024.

B. Policy: The following policy changes for FY 2024 went on display on August 1, 2023 and appeared in the Federal Register on August 28, 2023. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2023 through September 30, 2024, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released that include the updated rates/factors/policies that are effective for claims with discharges occurring on or after October 1, 2023 through September 30, 2024. The new revised Pricer program shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

The FY 2024 Final Rule Data Files, FY 2024 Final Rule Tables, and FY 2024 MAC Implementation Files referenced throughout this CR are available on the CMS website. Medicare Administrative Contractors (MACs) shall use these files (when not otherwise specified) which are available at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page.

Alternatively, the files on the webpage 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 2024 IPPS Final Rule Home Page” or the link titled “Acute Inpatient--Files for Download” (and select ‘Files for FY 2024 Final Rule’).

IPPS FY 2024 Update

A. FY 2024 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 2024 IPPS/LTCH PPS Final Rule, available on the FY 2024 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 File 1 available on the FY 2024 MAC Implementation Files webpage.

B. FY 2024 Puerto Rico Hospital Update Under the IPPS

Section 1886(n)(6)(B) of the Act was amended to specify that the adjustments to the applicable percentage increase under section 1886(b)(3)(B)(ix) of the Act apply to subsection (d) Puerto Rico hospitals that are not meaningful electronic health record (EHR) users, effective beginning FY 2022. Accordingly, for FY 2022 and subsequent fiscal years, any subsection (d) Puerto Rico hospital that is not a meaningful EHR user as defined in section 1886(n)(3) of the Act and not subject to an exception under section 1886(b)(3)(B)(ix) of the Act will have a reduction applied to the applicable percentage increase.

Therefore, beginning with FY 2022 for Puerto Rico hospitals, MACs shall enter a 'Y' in Data Element 58 (Electronic Health Records (EHR) Program Reduction) in the PSF if the hospital is subject to a reduction due to NOT being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user. MACs will be notified which Puerto Rico hospitals will be subject to the reduction for FY 2024 under separate cover.

For the applicable operating standardized amount and corresponding update factor for hospitals in Puerto Rico, refer to Table 1C of the FY 2024 IPPS/LTCH PPS Final Rule, available on the FY 2024 Final Rule Tables webpage.

C. 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 International Classification of Diseases Tenth Revision (ICD-10) MS-DRG Grouper, Version 41.0, software package effective for discharges on or after October 1, 2023. The GROUPER assigns each case into an 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 41.0, 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, 2023.

For discharges occurring on or after October 1, 2023, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors received the GROUPER documentation August 2023.

For discharges occurring on or after October 1, 2023, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors received the MCE documentation in August 2023. Note that the MCE version continues to match the Grouper version.

CMS reduced the number of MS-DRGs by one, for a total of 766 for FY 2024.

See the ICD-10 MS-DRG V41.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V41 manual located on the MS-DRG Classifications and Software webpage (at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software) for the complete list of FY 2024 ICD-10 MS-DRGs and Medicare Code Edits.

D. Replaced Devices Offered without Cost or with a Credit

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.

See MAC Implementation File 7 for the complete list of MS-DRGs covered under the Replaced Devices Offered without Cost or with a Credit in FY 2024. There were MS-DRG changes under this policy for FY 2024.

E. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2024 have been evaluated against the general post-acute care transfer policy criteria using the FY 2022 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review new MS–DRGs 276 and 277 will be added to the list of MS-DRGs subject to the post-acute care transfer policy and the special payment policy.

See Table 5 of the FY 2024 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2024 Final Rule Tables webpage.

F. New Technology Add-On Payment Policy

For FY 2024, 11 technologies continue to be eligible for new technology add-on payments, and 21 new applications are eligible for 19 new technology add-on payments. One technology was granted conditional approval pending FDA marketing authorization, and additional instructions will be issued if FDA marketing authorization is granted in time for FY 2024 payments under the conditional approval policy. For more information on FY 2024 new technology add-on payments, specifically regarding the technologies either continuing to receive payments or beginning to receive payments, refer to MAC Implementation File 8 available on the FY 2024 MAC Implementation Files webpage. MAC Implementation File 8 also includes information regarding technologies no longer eligible to receive new technology add-on payments.

G. FY 2024 Labor Related Share Percentage

There are no changes to the labor-related share percentages under the IPPS for FY 2024. For reference, see MAC Implementation File 1 available on the FY 2024 MAC Implementation Files webpage for the labor related share percentages for FY 2024. No MAC action is necessary as Pricer will apply the labor-related share percentages for FY 2024.

H. Cost of Living Adjustment (COLA) for Hospitals Paid Under the IPPS

There are no changes to the COLA factors for FY 2024. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2023, can be found in the FY 2024 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2024 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2024.)

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

MACs shall update the PSF by following the steps, in order, in the file on the FY 2024 MAC Implementation Files webpage ("Instructions to Fill Out the PSF for the Wage Index and Reclassifications.pdf" in MAC Implementation File 5) to determine the appropriate wage index and other payments. We note, the file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications.pdf" includes steps to update the PSF to ensure that IPPS payments for hospitals with reclassifications and redesignations are paid appropriately.

For hospitals listed in Table 2 on the CMS website at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page, CMS is providing a spreadsheet by provider that can be used as a guide to fill in the PSF based on the information available at the time of the FY 2024 IPPS Final Rule. Since this spreadsheet is based on a hospital's geographic and reclassification information at the time of the FY 2024 IPPS Final Rule, it should only be used as a guide. The spreadsheet should NOT be relied upon as the final source to update the PSF (as more recent geographic or reclassification information for a hospital may become available subsequent to the development of the final rule). The file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications.pdf" in MAC Implementation File 5 contains complete details filling in the PSF regarding ALL circumstances related to the wage index and is to be relied upon as the final

source how to update the PSF.

For hospitals located in rural counties that are deemed Lugar counties on Table 4B (that is, counties redesignated under section 1886(d)(8)(B) of the Act), MACs must verify and ensure that a hospital's Lugar status is applied appropriately. See MAC Implementation File 5 for complete details on how to fill-out the PSF for such hospitals.

For FY 2024, the following policies will apply to the wage index:

- Increase the wage index values for hospitals with a wage index value below the 25th percentile wage index value for FY 2024 across all hospitals. For reference, see MAC Implementation File 1 available on the FY 2024 MAC Implementation Files webpage for the 25th percentile wage index value for FY 2024. No MAC action is necessary as Pricer will apply the 25th percentile wage index value for FY 2024.
- Apply a 5 percent cap for FY 2024 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2023.
- Effective for FY 2024, wage data from hospitals with dual 42 CFR 412.103 rural reclassifications and MGCRB reclassifications will be included in rural wage index calculations. This policy has no implications for the MACs, but it does change how we compute the rural floor.

Per Change Request 11707, we created two PSF fields, the Supplemental Wage Index field (data element 63) and the Supplemental Wage Index Flag (data element 64). For FY 2024, for all hospitals eligible for the 5 percent cap, the Supplemental Wage Index Flag (data element 64) must be "1" and the Supplemental Wage Index field (data element 63) shall equal the wage index in Table 2 in the column labeled "FY 2023 Wage Index" to implement the 5 percent cap policy indicated above. These fields are used by the Pricer to determine the 5 percent cap on the decrease in a hospital's wage index, as applicable. Under the 5 percent cap policy, new hospitals that opened during FY 2024 are not eligible for the 5 percent cap. Therefore, for newly opened hospitals in FY 2024, the Supplemental Wage Index Flag field (data element 64) shall be blank and the value in the Supplemental Wage Index field (data element 63) shall be zeroes. For hospitals not listed on Table 2 (other than new hospitals opened in FY 2024) or any other issues, see MAC Implementation File 5 available on the FY 2024 MAC Implementation Files webpage for complete instructions.

If a MAC believes use of 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) is necessary for FY 2024, the MAC shall seek approval from the CMS Central Office prior to entering 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). We refer MACs to the FY 2024 MAC Implementation Files webpage and the file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications" for complete details for filling in the PSF regarding ALL circumstances related to the wage index.

J. Multicampus Hospitals

CMS 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 MAC Implementation File 5). 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 2024 in which a multicampus hospital

with inpatient campuses located in different CBSAs is created, please contact WageIndex@cms.hhs.gov for instructions.

K. Treatment of Hospitals Redesignated Under Section 1886(d)(8)(B) of the Act (Lugar Hospitals) Other Than for Wage Index Purposes

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 under section 1886(d) of the Act are determined based upon the urban area to which they are redesignated.

For purposes of IPPS provider type or hospital status determinations (other than for determining a hospital's wage index, which is addressed above in section I.I,), MACs shall ensure they are taking into account the Lugar status of the hospitals and determining the payment and/or hospital status appropriately. Lugar counties that are deemed urban are listed on Table 4B of each fiscal year's IPPS final rule (or correcting document, as applicable). MACs shall verify whether a hospital is located in a Lugar county based on the list of counties in Table 4B. MACs shall not rely on Table 2 to determine whether a hospital has Lugar status as hospital statuses can change. **Note:** MACs shall also verify whether the hospital has an urban-to-rural 412.103 reclassification which impacts the hospital's urban/rural status. Hospitals located in a Lugar county with active 412.103 reclassifications are considered rural for IPPS payment purposes that are dependent on urban/rural status. Also, hospitals that waive Lugar status to receive the out-migration adjustment are considered rural for IPPS payment purposes that are dependent on urban/rural status. For a list of hospitals that waived Lugar status for FY 2024, see MAC Implementation File 5. (Note, the list of hospitals that waived Lugar status can change each Fiscal Year.)

For example, MACs shall determine whether the hospital is located in a Lugar county when determining eligibility for SCH or MDH classification. In the absence of an active 412.103 reclassification or a waiver of Lugar status to receive the out-migration adjustment, a hospital that is located in a Lugar county is considered urban for this purpose.

L. Change of Effective Date for Sole Community Hospital Status and 412.103 Rural Reclassification in the Case of a Merger

42 CFR § 412.92(b)(2)(vi) implements provisions for retroactive classification as a sole community hospital (SCH) when providers become eligible for SCH status under § 412.92(a) by merging with a nearby like hospital, as defined in § 412.92(c)(2). Providers that submit a complete SCH application on or after October 1, 2023 and within 90 days of receiving CMS' written approval of the merger are entitled to SCH status retroactive to the effective date of the merger. (Please note that a complete application for such a provider includes a copy of CMS' written approval of the merger in addition to relevant documentation specified in the Provider Reimbursement Manual 15-1 § 2810(B).) For those providers that fail to submit a complete SCH application within 90 days of CMS' notification of the merger approval, SCH classification would be effective as of the date the MAC receives the complete application, including documentation of the merger approval, consistent with § 412.92(b)(2)(i) and SCH application instructions in CR 10869 (Transmittal 4144; October 4, 2018).

A conforming change to 42 CFR § 412.103(d) modifies the effective date of rural reclassification for a hospital that, by merging with another like hospital, meets all criteria for SCH status under § 412.92(a), except for being located in a rural area. Such a hospital would thereby qualify for rural reclassification under § 412.103(a)(3). The effective date for a hospital applying under such circumstances will be the effective date determined under § 412.92(b)(2)(vi).

M. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2024

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, 2024.

For FY 2024, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2023, in order for the applicable low-volume payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2023 (through September 30, 2024). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2023 may continue to receive a low-volume hospital payment adjustment for FY 2024 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2024.

Accordingly, for FY 2024, such a hospital must send written verification that is received by its MAC no later than September 1, 2023, stating that it meets the mileage criterion applicable for FY 2024. If a hospital's request for low-volume hospital status for FY 2024 is received after September 1, 2023, and if the MAC determines 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 2024 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For FY 2024 discharges, the Pricer will calculate the low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF using the adjustment factor value in the LV Adjustment Factor field on the PSF. Therefore, if a hospital qualifies for the low-volume hospital payment adjustment for FY 2024, the MAC shall ensure the low-volume indicator field on the PSF (position 74 – temporary relief indicator) holds a value of 'Y'. For such hospitals, the MAC shall also update the LV Adjustment Factor field on the PSF (positions 252 - 258) with a value greater than 0 and less than or equal to 0.25, determined using the low-volume hospital payment adjustment factor formula at 42 CFR 412.101(c)(3). Likewise, if a hospital qualified for the low-volume hospital payment adjustment for FY 2023 but no longer meets the low-volume hospital definition for FY 2024, and therefore the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective October 1, 2023, the MAC shall update the low-volume indicator field to hold a value of 'blank' and update the LV Adjustment Factor on the PSF to hold a value of 'blank'.

N. Medicare Advantage (MA) Nursing and Allied Health (NAH) Education Payments – Rates for CYs 2020, 2021 and 2022

Under 42 CFR 413.87, hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs and treat Medicare Advantage enrollees receive additional payments. Determining a hospital's NAH MA payment essentially involves applying a ratio of the hospital-specific NAH Part A payments, total inpatient days, and MA inpatient days, to national totals of those same amounts, from cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year. The formula is as follows:

(((Hospital NAH pass-through payment/ Hospital Part A Inpatient Days) * Hospital MA Inpatient Days) / ((National NAH pass-through payment/ National Part A Inpatient Days) * National MA Inpatient Days)) * Current Year Payment Pool.

In the FY 2023 IPPS/LTCH final rule (87 FR page 49075), we published the final national rates and percentages, and their data sources for CYs 2020 and 2021. MACs shall use these rates to make MA N&AH payments and DGME payments to applicable providers for portions of cost reporting periods occurring in CYs 2020 and 2021. For policy guidance on these payments, MACs may refer to CR 11642.

In the FY 2024 IPPS/LTCH final rule (citation information forthcoming), we published the final national rates and percentages, and their data sources for CY 2022. MACs shall use these rates to make MA N&AH payments and DGME payments to applicable providers for portions of cost reporting periods occurring in

CY 2022.

O. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed on the following CMS QualityNet web site: https:/www.qualitynet.org/inpatient/iqr/apu. 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 the 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 2024 under the Hospital IQR Program are found in MAC Implementation File 3, available on the FY 2024 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.

P. Hospital-Acquired Condition (HAC) Reduction Program

For FY 2024, hospitals have until late-September 2023 to notify CMS of any errors in the calculation of their Total HAC Score under the Scoring Calculations Review and Correction period. Because of the delay in the Scoring Calculations Review and Correction period, the list of hospitals that are subject to the HAC Reduction Program for FY 2024 will not be available by October 1, 2023.

Until CMS issues a final list of hospitals that are subject to the HAC Reduction Program for FY 2024, contractors shall hold hospital claims. CMS anticipates issuing the list on or about October 3, 2023.

Upon receipt of the final list of hospitals that are subject to the HAC Reduction Program for FY 2024, MACs shall update the "HAC Reduction Indicator" field in the PSF with an effective date of October 1, 2023 as follows, and then release the claims:

- For hospitals in the list of hospitals subject to the HAC Reduction Program for FY 2024 that have a "Y" in Column D (Worst-Performing Quartile), enter a "Y" in the "HAC Reduction Indicator" field (data element 56) in the PSF;
- For hospitals in the list of hospitals subject to the HAC Reduction Program for FY 2024 that have an "N" in Column D (Worst-Performing Quartile), enter an "N" in the "HAC Reduction Indicator" field (data element 56) in the PSF.

Q Hospital Value-Based Purchasing (VBP) Program

For FY 2024, CMS will implement the base operating MS-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 2024. CMS expects to post the final value-based incentive payment adjustment factors for FY 2024 in the near future in Table 16B of the FY 2024 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2024 IPPS/LTCH PPS final rule Tables webpage). (MACs will receive subsequent communication when value-based incentive payment adjustment factors for FY 2024 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 2024 IPPS/LTCH PPS final rule are proxy values. These values are not to be used to adjust payments.

Until CMS issues final values in Table 16B, contractors shall enter 'N' in the VBP Participant field

R. Hospital Readmissions Reduction Program (HRRP)

CMS expects to post the HRRP payment adjustment factors for FY 2024 in the near future in Table 15 of the FY 2024 IPPS/LTCH PPS final rule (which are available via the Internet on the FY 2024 IPPS/LTCH PPS Final Rule Tables webpage). (MACs will receive subsequent communication when the HRRP payment adjustment factors for FY 2024 in Table 15 are available.) Hospitals that are not subject to a reduction under the HRRP in FY 2024 (such as Maryland hospitals), have an HRRP payment adjustment factor of 1.0000. For FY 2024, hospitals should only have an HRRP payment adjustment factor between 1.0000 and 0.9700. (Note the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) field in the PSF refers to the HRRP payment adjustment factor.)

Upon receipt of this file, the MACs shall update the Hospital Readmissions Reduction Program participant (HRR Indicator) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF with an effective date of October 1, 2023 as follows:

- If a provider has an HRRP payment adjustment factor on Table 15, MACs shall input a value of '1' in the HRR Indicator field and enter the HRRP payment 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 Indicator field and leave the HRR Adjustment field blank.

Until CMS issues final values, contractors shall enter '0' in the HRR Indicator field.

S. Medicare Disproportionate Share Hospitals (DSH) Program

Counting Days Associated With Section 1115 Demonstrations in the Medicaid Fraction

In the FY 2024 IPPS/LTCH PPS Final Rule, effective with discharges on or after October 1, 2023, CMS finalized changes to the regulations governing the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations in the Medicaid fraction. Under this finalized policy, only the days of those patients who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100% of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services, are to be included, provided in either case that the patient is not also entitled to Medicare Part A. In addition, days of patients for which hospitals are paid from demonstration-authorized uncompensated/undercompensated care pools may not be included.

Uncompensated Care Payments

In the FY 2024 IPPS/LTCH PPS Final Rule, CMS finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount to be paid to Medicare DSH hospitals along with a total uncompensated care payment amount. Interim uncompensated care payments will continue to be paid on the claim as an estimated per claim amount to the hospitals that have been projected to receive Medicare DSH payments in FY 2024. The estimate Per Claim Amount and Projected DSH Eligibility for each Subsection (d) hospital and Subsection (d) Puerto Rico hospital are located in the Medicare DSH Supplemental Data File for FY 2024, which is available via the Internet on the FY 2024

Final Rule Data Files webpage.

MACs shall enter the updated estimated per claim uncompensated care payment amounts or if the hospital is a IHS/Tribal hospital or hospital located in Puerto Rico, enter the total of the estimated per discharge UCP amount and estimated per discharge supplemental payment amount, in data element 57 in the PSF from the FY 2024 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File. For IHS/Tribal hospitals and hospitals located in Puerto Rico, the total amount from the DSH Supplemental Data File, is the combined total for both uncompensated care payment per discharge amount and the supplemental payment per discharge amount (see section T below for additional information). The interim estimated uncompensated care payments that are paid on a per claim basis will be reconciled at cost report settlement with the total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File. The interim estimated supplemental payments that are paid on a per claim basis will be reconciled at cost report settlement using the total supplemental payment displayed in the Medicare DSH Supplemental Data File.

Hospitals without prospective FY 2024 Factor 3 calculation (New Hospitals, Uncompensated Care Trim and Newly Merged Hospitals)

For FY 2024, new hospitals for uncompensated care payment purposes, that is, hospitals with CCNs established after October 1, 2020, that are determined to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the uncompensated care costs from the hospital's FY 2024 cost report, as reported on Line 30 of Worksheet S-10 (annualized, if needed) as the numerator. The denominator used for this calculation can be found in the FY 2024 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Then, Factor 3 is multiplied by a scaling factor and multiplied by the total uncompensated care payment amount finalized in the FY 2024 IPPS Final Rule to determine the total uncompensated care payment amount to be paid to the hospital, if the hospital is determined DSH eligible at cost report settlement.

For new hospitals, newly merged hospitals, and hospitals subject to the Uncompensated Care Data Trim, the MAC shall apply a scaling factor for the Factor 3 calculation, if the hospital is determined DSH eligible at cost report settlement. The scaling factor used for the calculation can be found in the FY 2024 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description or in the MAC Implementation File 1 available on the FY 2024 MAC Implementation Files webpage.

If a new hospital has a CCR on line 1 of Worksheet S-10 in excess of the threshold in MAC Implementation File 1, MACs shall contact Section3133DSH@cms.hhs.gov for further instructions on how to calculate the uncompensated care costs for the numerator. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as a new hospital for purposes of DSH uncompensated care payments. However, CMS notes, it is possible that there will be additional new hospitals during FY 2024 and therefore those would not be available to be listed on the Medicare DSH Supplemental Date File.

In the FY 2024 final rule, CMS continued an additional Uncompensated Care Data Trim for hospitals that were not projected DSH eligible for purposes of interim uncompensated care payments. Similar to new hospitals, the hospitals impacted by this new trim, do not have a Factor 3 listed in the FY 2024 Medicare DSH Supplemental File. If the hospital subject to the data trim, is ultimately determined DSH eligible at cost report settlement, then the MAC shall review Worksheet S-10 and calculate a Factor 3 from the hospital's FY 2024 cost report's Worksheet S-10 line 30 divided by the national uncompensated care cost denominator.

For FY 2024, newly merged hospitals, e.g., hospitals that have a merger during FY 2024 or mergers not known at the time of development of the final rule, will have their interim uncompensated care payments reconciled at cost report settlement by the MAC.

Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

For FY 2024, CMS used a 2-year average of the number of discharges for a hospital to produce an estimate of the amount of the uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount, is divided by the hospital's historical 2-year average of discharges computed using the most recent available data. The result of that calculation is a per discharge payment amount that is used to make interim uncompensated care payments to each projected DSH eligible hospital. The interim uncompensated care payments made to the hospital during the fiscal year are reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

Under this policy, if a hospital submits a request to its MAC, for a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the Federal fiscal year and/or once during the Federal fiscal year, then the MAC shall review the request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment (for example, 10 percent or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if the per discharge amount were not lowered. Examples include, but are not limited to, the following:

1. a request showing a large projected increase in discharges during the fiscal year to support reduction of its per discharge uncompensated care payment amount.
2. a request that its per discharge uncompensated care payment amount be reduced to zero midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital.

The MAC shall evaluate the request for strictly reducing the per discharge uncompensated payment amount and the supporting documentation before the beginning of the Federal fiscal year and/or with midyear request when the 2-year average of discharges is lower than hospital's projected FY 2024 discharges. If following review of the request and the supporting documentation, the MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change that would be made would be to lower the per discharge amount either to the amount requested by the hospital or another amount determined by the MAC to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request does not change how the total uncompensated care payment amount shall be reconciled at cost report settlement. The interim uncompensated care payments made to the hospital during the fiscal year are still reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

T. Supplemental Payment for Indian Health Service and Tribal hospitals and hospitals located in Puerto Rico

For the supplemental payment for IHS and Tribal hospitals and hospitals located in Puerto Rico, we based eligibility to receive interim supplemental payments on a projection of DSH eligibility for the applicable fiscal year. The DSH Supplemental Data File includes the combined interim uncompensated care payment and interim supplemental payment.

The MAC shall make a final determination with respect to a hospital's eligibility to receive the supplemental payment for a fiscal year, in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that fiscal year. If a hospital is determined not to be DSH eligible for a fiscal year, then the hospital would not be eligible to receive a supplemental payment for that fiscal year.

The MAC shall reconcile the interim supplemental payments at cost report settlement to ensure that the DSH eligible hospital receives the full amount of the supplemental payment that was determined prior to the start of the fiscal year. Projected DSH eligible hospitals have a total supplemental payment available in the Medicare DSH Supplemental Data File.

Consistent with the process used for uncompensated care payments cost reporting periods that span multiple Federal fiscal years, a pro rata supplemental payment calculation must be made if the hospital's cost reporting period differs from the Federal fiscal year. Thus, the final supplemental payment amounts to be included on a cost report spanning two Federal fiscal years are the pro rata share of the supplemental payment associated with each Federal fiscal year. This pro rata share is determined based on the proportion of the applicable Federal fiscal year that is included in that cost reporting period.

U. Outlier Payments

IPPS Statewide Average CCRs

Tables 8A and 8B contain the FY 2024 Statewide average operating and capital Cost-to-Charge ratios (CCRs) for urban and rural hospitals. Tables 8A and 8B are available on the FY 2024 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.84(i)(3)(iv)(C), for FY 2024, 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. Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with §412.8(b). For FY 2024 operating CCR and capital CCR trim values, refer to MAC Implementation File 1 available on the FY 2024 MAC Implementation Files webpage.
3. Hospitals for whom accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 20.1.2.1 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

Additionally, for all hospitals, use of an operating and/or capital CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

V. Payment Adjustment for Clinical Trial and Expanded Access Use Immunotherapy Cases in MS-DRG 018

CMS makes an adjustment to the payment amount for clinical trial and expanded access use immunotherapy cases that group to MS-DRG 018. For reference, see MAC Implementation File 1 available on the FY 2024 MAC Implementation Files webpage for the FY 2024 MS-DRG weighting factor used for such discharges.

Under this policy, a payment adjustment will be applied to claims that group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or when there is expanded access use of immunotherapy. However, when the CAR T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, the payment adjustment will not be applied in calculating the payment for the case.

In a case where there was expanded access use of CAR T-cell therapy or other immunotherapy products, the provider may submit condition code "90" on the claim so that the Pricer will apply the payment adjustment in calculating the payment for the case. To notify the MAC of a case where the CAR T-cell therapy or other

immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product (and ICD-10-CM diagnosis code Z00.6 on the claim), the provider may enter a Billing Note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim, and MACs shall add payer-only condition code "ZC" so that the Pricer will not apply the payment adjustment in calculating the payment for the case.

LTCH PPS FY 2024 Update

A. FY 2024 LTCH PPS Rates and Factors

The FY 2024 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2024 Final Rule Tables webpage. Other FY 2024 LTCH PPS Factors can be found in MAC Implementation File 2 available on the FY 2024 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 41 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2023, and on or before September 30, 2024.

B. 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 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. CMS notes business requirements (BRs) 11361.11 and 11361.11.1 continue to apply.

Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods beginning on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that is not at least 50 percent be informed of such a fact; and section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH's discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by section 1886(m)(6)(C)(iii) of the Act. CMS notes BRs 11616.11, 11616.11.1. 11616.11.2 and 11616.11.3 continue to apply, subject to the provisions of Section 3711(b)(1) of the CARES Act for the duration of the COVID-19 public health emergency period, which expired at the end of the day on May 11, 2023. (Refer to Change Request 11742 for additional implementation on information on section 3711(b)(1) of the CARES Act.)

C. LTCH Quality Reporting (LTCHQR) Program

Under the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, for FY 2024, 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.

D. 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, 2023, or effective with cost reporting periods that begin on or after October 1, 2023, or upon receipt of an as-filed (tentatively) settled cost report.

LTCH Statewide Average CCRs

Table 8C contains the FY 2024 Statewide average LTCH total Cost-to-Charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2024 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 2024, Statewide average CCRs are used in the following instances:

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).

1. LTCHs with a total CCR in excess of the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR). For the FY 2024 LTCH total CCR ceiling, refer to MAC Implementation File 2 available on the FY 2024 MAC Implementation Files webpage.
2. Any hospital for which data to calculate a CCR is not available.

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.

Additionally, for all LTCHs, use of a total CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

LTCH Labor Market Areas and Wage Indexes

For FY 2024, a 5 percent cap will be applied to any decrease in an LTCH's wage index from its FY 2023 wage index. A list of LTCHs whose FY 2024 LTCH PPS wage index decreased by more than 5 percent along with their capped FY 2024 LTCH PPS wage index value can be found on the FY 2024 MAC Implementation Files webpage. For these LTCHs, MACs will enter into the PSF a '1' in the Special Payment Indicator field (data element 33) and the LTCH's capped FY 2024 LTCH PPS wage index value in the Special Wage Index field (data element 38). We note that hospitals newly classified as an LTCH during FY 2024 are not eligible for the 5 percent cap. If a MAC believes that an LTCH is either incorrectly included or excluded from the list of LTCHs that receive the 5 percent cap for the FY 2024 LTCH PPS wage index, please contact LTCHPPS@cms.hhs.gov for further instructions.

For FY 2024, a 5 percent cap will also be applied to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2023 applicable IPPS comparable wage index. A list of LTCHs whose FY 2024 applicable IPPS comparable wage index decreased by more than 5-percent along with their capped FY 2024 applicable IPPS comparable wage index value can be found on the FY 2024 MAC Implementation Files webpage. For these LTCHs, MACs will enter into the PSF a '2' in the Supplemental Wage Index Flag field (data element 64) and the LTCH's capped FY 2024 applicable IPPS comparable wage index value in the Supplemental Wage Index field (data element 63). We note that hospitals newly classified as an LTCH during FY 2024 are not eligible for the 5 percent cap. If a MAC believes that an LTCH is either incorrectly included or excluded from the list of LTCHs that receive the 5 percent cap for the FY 2024 applicable IPPS comparable wage index, please contact LTCHPPS@cms.hhs.gov for further instructions.

E. Cost of Living Adjustment (COLA) under the LTCH PPS

There are no updates to the COLAs for FY 2024. The COLAs effective for discharges occurring on or after October 1, 2023 can be found in the FY 2024 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2024 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2024.)

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 2024 IPPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2024 of 3.3 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	
13306.1	Contractors shall access the IPPS Pricer via the Cloud to pay FY 2024 IPPS payment rates on claims with discharge dates on or after October 1, 2023.	X								
13306.2	Contractors shall access the LTCH PPS Pricer via the Cloud to pay FY 2024 LTCH payment rates on claims with discharge dates on or after October 1, 2023.	X								
13306.3	The Medicare contractor shall install and edit claims with the MCE version 41.0 and Grouper version 41.0 software with the implementation of the FY 2024 October quarterly release.					X				
13306.4	The 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				
13306.5	Medicare contractors shall inform the Quality Improvement Organization (QIO) of any new hospital that has opened for hospital quality purposes.	X								
13306.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR prior to the implementation of the FY 2024 IPPS and LTCH Pricers.	X								
13306.6.1	Medicare contractors shall follow the instructions in the policy section and on the FY 2024 MAC Implementation Files webpage to update the PSF and	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	ensure that the CBSA is assigned properly for all IPPS providers. **NOTE**: MACs shall follow these instructions for the following: All current IPPS hospitals; any new hospitals that open during FY 2024; or any change of hospital status during FY 2024.									
13306.6.2	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no IPPS provider has an operating CCR or a capital CCR in the PSF that is in excess of the FY 2024 applicable IPPS CCR ceilings. Additionally, use of an operating and/or capital CCR of 0.0 requires approval from the CMS Central Office.	X								
13306.6.3	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no LTCH has a total CCR in the PSF that is in excess of the FY 2024 total CCR ceiling. Additionally, use of a total CCR of 0.0 requires approval from the CMS Central Office.	X								
13306.6.4	MACs shall ensure they are taking into account the Lugar status of a hospital and apply the payment and/or hospital status appropriately. See instructions in sections I.I and I.K for complete details.	X								
13306.7	Medicare contractors shall be aware that a hospital may request a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the Federal fiscal year and/or once during the Federal fiscal year, as described in the policy section.	X								
13306.7.1	Medicare contractors shall evaluate the request for reducing the per discharge uncompensated payment amount and the supporting documentation, and update the PSF, if applicable, as described in the policy section.	X								
13306.7.2	Medicare contractors shall review Worksheet S-10 for new hospitals and hospitals subject to the new trim, if the hospital(s) is determined DSH eligible at cost report settlement. Additionally, if such a hospital is determined to be DSH eligible, Medicare contractors shall calculate a Factor 3 based on the Worksheet S-10	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	from the hospital's FY 2024 cost report.									
13306.8	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								
13306.9	Medicare contractors shall be aware of any manual updates included within this CR.	X								
13306.10	The CWF shall update and edit IUR 7272 and 7800 as necessary for the post-acute DRGs listed in Table 5 of the IPPS Final Rule when changes are made. **NOTE**: New MS-DRGs 276 and 277 were added to the list of MS-DRGs subject to the post-acute care transfer policy and the special payment policy listed in Table 5 in the FY 2024 IPPS Final Rule.								X	
13306.11	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 element 38).	X								
13306.12	For FY 2024 (discharges on or after October 1, 2023), for hospitals paid under the IPPS, for all hospitals eligible for the 5 percent cap, the MAC shall enter a "1" in the Supplemental Wage Index Flag field (data element 64) and the Supplemental Wage Index field (data element 63) shall be equal the wage index in Table 2 in the column labeled "FY 2023 Wage Index". See MAC Implementation File 5 available on the FY 2024 MAC Implementation Files webpage for complete instructions.	X								
13306.12.1	For hospitals paid under the IPPS, new hospitals that open during FY 2024 are not eligible for the 5 percent cap. Therefore, for newly opened hospitals in FY 2024, the Supplemental Wage Index Flag field (data element 64) shall be blank and the Supplemental Wage Index field (data element 63) shall be zeroes. For hospitals not listed on Table 2 (other than new hospitals opened in FY 2024) or any other issues regarding the 5 percent cap policy, see MAC Implementation File 5 available on the FY 2024 MAC Implementation Files webpage for complete	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	instructions.									
13306.13	For FY 2024 (discharges on or after October 1, 2023), for hospitals paid under the LTCH PPS, for all LTCHs receiving the 5 percent cap on their FY 2024 LTCH PPS wage index, the MAC shall enter a "1" Special Payment Indicator field (data element 33) and the LTCH's capped FY 2024 LTCH PPS wage index value in the Special Wage Index field (data element 38). See MAC Implementation File 9 available on the FY 2024 MAC Implementation Files webpage for complete instructions.	X								
13306.14	For FY 2024 (discharges on or after October 1, 2023), for hospitals paid under the LTCH PPS, for all LTCHs receiving the 5 percent cap on their FY 2024 applicable IPPS comparable wage index, the MAC shall enter a '2' in the Supplemental Wage Index Flag field (data element 64) and the LTCH's capped FY 2024 applicable IPPS comparable wage index value in the Supplemental Wage Index field (data element 63). See MAC Implementation File 9 available on the FY 2024 MAC Implementation Files webpage for complete instructions.	X								
13306.15	MACs shall enter a 'Y' in Data Element 58 (Electronic Health Records (EHR) Program Reduction) in the PSF if the hospital is subject to a reduction due to NOT being an EHR meaningful user.	X								
13306.16	The Medicare contractor shall update the list of MS-DRGs subject to the editing and payment policy for replaced devices offered without cost or with a credit effective for discharges on or after 10/01/2023.					X				
13306.17	Effective October 1, 2023, Medicare contractors shall update the low-volume indicator (position 74 - temporary relief indicator) and the LV Adjustment Factor field in the PSF (positions 252 - 258) for providers that meet the low-volume hospital discharge and mileage criteria for FY 2024 as described in the policy section, and for providers that no longer qualify as a low-volume hospital as described in the policy section.	X								
13306.18	The Medicare contractors shall hold claims from 10/1/2023 until the FY 2024 Hospital-Acquired	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Condition Reduction Program (HACRP) payment file is received on or about 10/3/2023.									
13306.19	The Medicare contractors shall make the updates to apply the HACRP payment adjustment and release the claims once the FY 2024 HACRP payment file is received on or about 10/3/2023.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13306.20	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	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

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: 0

Addendum A - Provider Specific File

(Rev.12234, Issued: 08-31-23, Effective: 10-01-2023, Implementation: 10-02-2023)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></tr>
<tr><td></td><td>11-16</td><td>X(6)</td><td>Provider CMS Certification Number (CCN)</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the provider CMS Certification Number (CCN) and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table></td></tr>
</table>

Data Element	File Position	Format	Title	Description
3	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a “Y” or “N.” Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).

Data Element	File Position	Format	Title	Description
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990). 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency

Data Element	File Position	Format	Title	Description
				37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the provider CMS Certification Number (CCN) (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific

Data Element	File Position	Format	Title	Description
				NOTE: When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate.

Data Element	File Position	Format	Title	Description
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** For "From" dates before 1/1/2021: Enter the value to indicate if normal percentage payments should be made on RAP and/or whether payment should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment

Data Element	File Position	Format	Title	Description
				1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments). For "From" dates on or after 1/1/2021: Enter the value to indicate whether payment should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2% **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** For cost reporting periods beginning on or after 10/01/2002, enter the appropriate code for the blend ratio between federal and facility rates for the LTCH provider: 1 — Federal % 20 — Facility% 80 2 — 40 — 60 3 — 60 — 40 4 — 80 — 20 5 — 100 — 00 For LTCH cost reporting periods beginning on or after 10/01/2015 enter the appropriate code for the blend year representing 50% site neutral payment and 50 % standard payment. **6 –Blend Year 1** (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015 through 09/30/16) **7 - Blend Years 2 through 4** (represents 50% site neutral payment and 50 %

Data Element	File Position	Format	Title	Description
				standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018 or FY 2019 **8 - Blank –** Transition Blend no longer applies with cost reporting periods beginning in on or after 10/01/2019. Full Site Neutral payment **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. 1 — Federal % 25 — Facility% 75 2 — 50 — 50 3 — 75 — 25 4 — 100 — 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the

Data Element	File Position	Format	Title	Description
				provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)

Data Element	File Position	Format	Title	Description
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.

Data Element	File Position	Format	Title	Description
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for each HHA. If no factor is provided, enter 1.00000.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will

Data Element	File Position	Format	Title	Description
				automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a "1" or "2."
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. Include pass through amount for Domestic N95 Respirator Procurement. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, DSH adjustments, or Allogeneic Stem Cell Acquisition. Zero-fill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.

Data Element	File Position	Format	Title	Description
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter “Y” if participating in Hospital Value Based Purchasing. Enter “N” if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.

Data Element	File Position	Format	Title	Description
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter "0" if not participating in Hospital Readmissions Reduction program. Enter "1" if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter "2" if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if "1" is entered in Data Element 53. Leave blank if "0" or "2" is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a 'Y' if the hospital is subject to a reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment (UCP) amount or enter the total of the estimated per discharge UCP amount and estimated per discharge supplemental payment amount, calculated and published by CMS for each hospital. Effective 10/1/2022, the estimated per discharge supplemental payment is for eligible Indian Health Service/Tribal hospitals and hospitals located in Puerto Rico.
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated in accordance with the low-volume hospital payment regulations at § 412.101.
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.

Data Element	File Position	Format	Title	Description
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	269-269	X(1)	LTCH DPP Indicator	Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.
63	270-275	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.
64	276-276	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag that certain providers may be assigned: 1=Prior Year Wage Index 2=Special IPPS-comparable Wage Index* 3=Future use Enter blank if it does not apply *Only for LTCH providers. Pricer will override the otherwise determined IPPS-comparable wage index with this value.
65	277-285	9(7)V99	Pass Through Amount for Allogeneic Stem Cell Acquisition	Enter the per diem amount based on the interim payments to the hospital. Include acquisition amounts for allogeneic stem cell transplants. Zero-fill if this does not apply.
66	286-291	9(4)V9(2)	Pass Through Amount for Direct Medical Education (Medicare Advantage (MA) Exclusion)	Per diem amount of direct graduate medical education to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.
67	292-297	9(4)V9(2)	Pass Through Amount for Kidney Acquisition (MA Exclusion)	Per diem amount of kidney acquisition costs to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.
68	298-306	9(7)V99	Pass Through Amount for	Enter the per diem amount based on the interim payments to the hospital. Include

Data Element	File Position	Format	Title	Description
			Domestic N95 Respirator Procurement	payment adjustments for the additional cost for procurement of wholly domestically made NIOSH-approved surgical N95 respirators.
69	307-310	X(4)	Filler	