

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3832	Date: August 9, 2017
	Change Request 9723

RE-ISSUE NOTE: Transmittal 3626, dated October 19, 2016, is being rescinded and replaced by Transmittal 3832, dated, August 9, 2017 to revise the out migration values in Attachment 7 and to remove the incorrect language from the correction statement issued on August 9, 2017. All other information remains the same.

SUBJECT: Fiscal Year (FY) 2017 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2017 update to the IPPS and LTCH PPS. This Recurring Update Notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2016

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 3, 2016

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/revise 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

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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. CMS is required to make updates to these prospective payment systems annually. This Change Request (CR) outlines those changes for FY 2017.

B. Policy: The following policy changes for FY 2017 were displayed in the Federal Register on August 02, 2016, with a publication date of August 22, 2016. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2016 through September 30, 2017, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2016, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2016 through September 30, 2017. The new revised Pricer program shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

IPPS FY 2017 Update

A. FY 2017 IPPS Rates and Factors

Refer to Table 1 in Attachment 1.

B. MS-DRG Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new ICD-10 MS-DRG Grouper, Version 34.0, software package effective for discharges on or after October 1, 2016. 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 34.0 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, 2016.

For discharges occurring on or after October 1, 2016, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should receive the GROUPER documentation in August 2016.

For discharges occurring on or after October 1, 2016, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should receive the MCE documentation in August 2016. Note that the MCE version continues to match the Grouper version.

Effective October 1, 2016, MS-DRGs 228 through 230 (Other cardiothoracic procedures w MCC, w CC and w/o CC/MCC, respectively) have been collapsed from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229.

CMS revised the following MS-DRG:

- MS-DRG 229 Other cardiothoracic procedures w/o MCC

CMS deleted the following MS-DRG:

- MS-DRG 230 Other cardiothoracic procedures w/o CC/MCC

Effective October 1, 2016, the title for MS-DRG 884 (Organic Disturbance and Mental Retardation) has been revised to MS-DRG 884 (Organic Disturbances and Intellectual Disability).

C. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2017 have been evaluated against the general post-acute care transfer policy criteria using the FY 2015 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 and special payment policy:

See Table 5 of the FY 2017 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the CMS website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>. Then click on the link on the left side of the screen titled, "FY 2017 IPPS Final Rule Home Page" or "Acute Inpatient Files for Download".

D. New Technology Add-On

The following items will *continue* to be eligible for new-technology add-on payments in FY 2017:

1. Name of Approved New Technology: CardioMEMS™ HF Monitoring System

- Maximum Add on Payment: \$8,875
- Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z

2. Name of Approved New Technology: Blinatumomab (BLINCYTO™)

- Maximum Add on Payment: \$27,017.85
- Identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351

3. Name of Approved New Technology: LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACT™Admiral™ Pacliaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter

- Maximum Add on Payment: \$1,035.72

- Identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441, 047K4D1, 047K4Z1, 047L041, 047L0D1, 047L0Z1, 047L341, 047L3D1, 047L3Z1, 047L441, 047L4D1, 047L4Z1, 047M041, 047M0D1, 047M0Z1, 047M341, 047M3D1, 047M3Z1, 047M441, 047M4D1, 047M4Z1, 047N041, 047N0D1, 047N0Z1, 047N341, 047N3D1, 047N3Z1, 047N441, 047N4D1, 047N4Z1

The following items will be eligible for new-technology add-on payments in FY 2017:

4. Name of Approved New Technology: MAGEC® Spinal Bracing Distraction system

- Maximum Add on Payment: \$15,750
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes XNS0032, XNS0432, XNS3032, XNS3432, XNS4032 or XNS4432.

5. Name of Approved New Technology: GORE IBE device system

- Maximum Add on Payment: \$5,250
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC0FZ; 04VC3EZ; 04VC3FZ; 04VC4EZ; 04VC4FZ; 04VD0EZ; 04VD0FZ; 04VD3EZ; 04VD3FZ; 04VD4EZ; or 04VD4FZ

6. 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: XW03331or XW04331

7. Name of Approved New Technology: Defitelio®

- Maximum Add on Payment:\$75,900
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 and XW04392

8. Name of Approved New Technology: Vistogard™

- Maximum Add on Payment:\$37,500
- Identify and make new technology add-on payments with any of the following ICD-10-PCS diagnosis codes T45.1X1A, T45.1X1D, T45.1X1S, T45.1X5A, T45.1X5D, and T45.1X5S in combination with ICD-10-PCS procedure code XW0DX82

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

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2017 IPPS/LTCH PPS final rule and is also displayed in Table 2 in Attachment 1.

F. FY 2017 Wage Index Changes and Issues

1. New Wage Index Labor Market Areas and Transitional Wage Indexes

a. 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.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, for the few hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, under the new OMB delineations, 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 beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

Note that for hospitals that are receiving the 3-year hold-harmless wage index, the transition is *only for the purpose of the wage index and does not affect the hospital's urban or rural status for any other payment purposes*.

b. As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56913), on July 15, 2015, OMB issued OMB Bulletin No. 15-01, which provides updates to and supersedes OMB Bulletin No. 13-01 that was issued on February 28, 2013. According to OMB, "this bulletin establishes revised delineations for the Nation's Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas. The bulletin also provides delineations of Metropolitan Divisions as well as delineations of New England City and Town Areas." A copy of this bulletin may be obtained on the Web site at: https://www.whitehouse.gov/omb/bulletins_default. OMB Bulletin No. 15-01 made the following changes that are relevant to the IPPS wage index:

- Garfield County, OK, with principal city Enid, OK, which was a Micropolitan (geographically rural) area, now qualifies as an urban new CBSA 21420 called Enid, OK.

Therefore, for providers located in Garfield County, OK, (SSA code 37230), MACs shall update the Provider Specific File with an effective date of October 1, 2016 and ensure that the Actual Geographic Location Core-Based Statistical Area (CBSA) field in the PSF (data element 35) reflects CBSA 21420 instead of Rural Oklahoma.

2. 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.

3. 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.

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 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. The court decisions in *Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services*, 794 F.3d 383 (3d Cir. 2015) and *Lawrence + Memorial Hospital v. Burwell*, No. 15-164, 2016 WL 423702 (2d Cir. Feb. 4, 2015) ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and § 412.103 reclassifications. Therefore, on April 18, 2016, we issued an interim final rule with comment period (CMS-1664-IFC) amending the regulations to conform to the court decisions. The IFC is effective April 21, 2016, and was finalized on August 2, 2016. The IFC allows hospitals nationwide that have an MGCRB reclassification or LUGAR status during FY 2016 and subsequent years the opportunity to simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or LUGAR status. The instructions for filling out the PSF in attachment 8 reflect these new regulations.

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 8 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 2017 in which a multicampus hospital with inpatient campuses located in different CBSAs is created, please contact Miechal.Lefkowitz@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 8 to determine the appropriate wage index based on policies mentioned above. Note: Attachment 8 includes references to Attachments 4, 5, 6 and 7.

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

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through September 30, 2017, as provided by section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Provider Types 14 and 15 continue to be valid through September 30, 2017.

In the CY 2016 OPPI Final Rule, CMS provided for a transition period for these hospitals to mitigate the financial impact of losing MDH status to hospitals that (1) lost their MDH status because they are no longer in a rural area due to the adoption of the new OMB delineations in FY 2015 and (2) have not reclassified from urban to rural under the regulations at §412.103 before January 1, 2016. During the transition period (January 1, 2016 through September 30, 2017), such hospitals ("qualifying former MDHs") will receive a transitional add-on payment. For discharges occurring on or after October 1, 2016, through September 30,

2017, qualifying former MDHs will receive an add-on payment equal to one-third of “the MDH add-on” (that is, one-third of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital’s hospital-specific rate). Information on the requirements implementing this transitional add-on payment for former MDHs can be found in CR 9408.

Based on the best available information, CMS has identified the hospitals it believes qualify for this transitional add-on payment. The Pricer logic has been modified to calculate this transitional add-on payment in the HSP-payment field in the Pricer for the qualifying hospitals identified by CMS. The MAC should contact Shevi Marciano CMS/Division of Acute Care at Shevi.Marciano@cms.hhs.gov if it becomes aware of any additional hospital(s) other than those identified by CMS as qualifying for this transitional add-on payment. Note, no changes to Provider Type field on the PSF are required (that is, the Provider Type field should **not** reflect MDH status for these providers).

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

For FY 2017, the Hospital-Specific (HSP) amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480, 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 FY 2014), and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2017

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015 extended the temporary changes to the low-volume hospital payment adjustment through September 30, 2017.

In order to qualify as a low-volume hospital in FY 2017, a hospital must be located more than 15 road miles from another “ subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges. For FY 2017, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2016 update of the FY 2015 MedPAR file. Table 14 of the FY 2017 IPPS/LTCH PPS final rule (which is available through the Internet on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html>) lists the “subsection (d)” ’ hospitals with fewer than 1,600 Medicare discharges based on the March 2016 update of the FY 2015 MedPAR file and their low-volume hospital payment adjustment for FY 2017 (if eligible). We note that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does **not** reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion as outlined in prior program guidance and the FY 2017 IPPS/LTCH PPS final rule.

To receive a low-volume hospital payment adjustment under § 412.101 for FY 2017, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2016, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2016. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2016 may continue to receive a low-volume hospital payment

adjustment for FY 2017 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2017 (as shown in Table 14 of the FY 2017 IPPS/LTCH PPS Final Rule) and the mileage criterion. However, the hospital must send written verification that is received by its MAC no later than September 1, 2016, stating that it continues to be more than 15 miles from any other “subsection (d)” hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. If a hospital’s written request for low-volume hospital status for FY 2017 is received after September 1, 2016, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC shall apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2017 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

For discharges occurring during FY 2017, if a hospital qualifies as a low-volume hospital, the low-volume hospital indicator field on the PSF (position 74 – temporary relief indicator) must contain a value of ‘Y’ and the new low volume payment adjustment factor field on the PSF (positions 252-258) must contain a value greater than 0 and less than or equal to 0.250000. To implement this, the Pricer will apply the applicable low-volume hospital payment adjustment factor from the PSF for hospitals that have a value of ‘Y’ in the low-volume hospital indicator field on the PSF. If a hospital qualified for the low-volume hospital payment adjustment in FY 2016 but no longer meets the low-volume hospital definition for FY 2017, and therefore, the hospital is no longer eligible to receive a low-volume hospital payment adjustment in FY 2017, the MAC must update the low- volume hospital indicator field on the PSF (position 74 - temporary relief indicator) to hold a value of ‘blank’ and ensure that the low volume payment adjustment factor field (positions 252-258) is blank. Note, CMS is no longer requesting the MAC notify CMS Central Office of the IPPS hospitals that qualify as low-volume hospitals.

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 2017 under the Hospital IQR Program are listed in Attachment 3.

For new hospitals, A/B MACs shall enter a ‘1’ in the PSF and provide information to the Quality Improvement Organization (QIO) as soon as possible so that the QIO 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 QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative. The MACs shall provide this information monthly to the QIO in the State in which the hospital has opened. It shall include the following:

- State Code
- Medicare Accept Date
- Provider Name
- Contact Name (if available)
- Provider ID number
- Telephone Number

N. Hospital Acquired Condition Reduction Program (HAC)

Section 3008 of the Affordable Care Act (ACA) establishes a program, beginning in FY 2015, for Inpatient Prospective Payment System (IPPS) hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain Hospital Acquired Conditions (HACs). Under the HAC Reduction Program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year.

A list of providers subject to the HAC Reduction Program for FY 2017 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 TDL. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

O. Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. Under its current agreement with CMS, Maryland hospitals are not subject to the Hospital VBP Program for the FY 2017 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§ 412.160 through § 412.162).

For FY 2017 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 2017. CMS expects to post the value-based incentive payment adjustment factors for FY 2017 in the near future in Table 16B of the FY 2017 IPPS/LTCH PPS final rule (which will be available through the Internet on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html>). (MACs will receive subsequent communication when value-based incentive payment adjustment factors for FY 2017 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 2017 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 2017 are in Table 15 of the FY 2017 IPPS/LTCH PPS final rule (which are available through the Internet on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html>). Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2017 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2017, 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, 2016.

- If a provider has a readmissions adjustment factor on Table 15, MACs shall input a value of '1' in the HRR Participant field and entered 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 2017) 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. Starting in FY 2014, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital's share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

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

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2017 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2017. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY2013-2015). MACs shall enter the updated estimated per discharge uncompensated care per claim payment amounts from Attachment 2 in data element 57 in the PSF. 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. 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.

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 2017 subject to the policy for replaced devices offered without cost or with a credit.

LTCH PPS FY 2017 Update

A. FY 2017 LTCH PPS Rates and Factors

FY 2017 LTCH PPS Rates and Factors are located in forthcoming Table 4 in Attachment 1.

The LTCH PPS Pricer has been updated with the Version 34.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2016, and on or before September 30, 2017.

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. Additional information on the final policies implementing the application of the site neutral payment rate can be found in the FY 2016 Final Rule (80 FR 49601-49623). Section 231 of the Consolidated Appropriations Act created a temporary exception to the site neutral payment rate for certain discharges from certain LTCHs. Additional information on the provisions of Section 231 can be found in the Interim Final Rule with Comment Period (IFC) published in the **Federal Register** on April 21, 2016 (81 FR 25430). Information on the final policies implementation of the provisions of section 231 can be found in the FY 2017 IPPS/LTCH Final Rule (81 FR 57068) Information on the requirements implementing the application of the site neutral payment rate can be found in CRs 9015 and 9599..

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.

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 (other than a sub-clause II 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.

C. 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 2017, 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)

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
9723.9	The CWF shall update edit and IUR 7272 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 2017 IPPS Final Rule.								X	
9723.10	For each LTCH's cost reporting period beginning on or after October 1, 2016, 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								
9723.10.1	For each LTCH's cost reporting period beginning on or after October 1, 2016, 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								
9723.11	IPPS Pricer shall correct the low volume add on payment logic for years 2011 through 2016 when the provider's discharges are exactly equal to 200.								IPPS Pricer	
9723.12	Medicare contractors shall reprocess claims from hospitals who have discharges equaling 200 and the claim's discharge date is in 2011 through 2016 when brought to their attention.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
9723.13	MLN Article: A provider education article related to this instruction will be	X				

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
	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.					

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, camidi@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.

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