CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4046	**Date: May 10, 2018**
	Change Request 10547

Transmittal 3986, dated March 02, 2018, is being rescinded and replaced by Transmittal 4046, dated, May 10, 2018, to remove the Sensitive and Controversial disclaimer, add reference to the proposed rule in the background section, to make clarifying changes to the policy section and to revise requirement 10547.2. All other information remains the same.

SUBJECT: Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Extensions per the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act Included in the Bipartisan Budget Act of 2018

I. SUMMARY OF CHANGES: This change request provides information and implementation instructions for Sections 50204, 50205 and 51005 of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act of 2018. The attached Recurring Update Notification applies to publication 100-04, chapter 3, sections 20.3.4 and 150.5.2**.**

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

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

Pub. 100-04	Transmittal: 4046	Date: May 10, 2018	Change Request: 10547

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EFFECTIVE DATE: October 1, 2017
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IMPLEMENTATION DATE: April 2, 2018

I. GENERAL INFORMATION

A. Background: On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. The new law includes the extension of certain provisions that had expired October 1, 2017. Specifically, the following Medicare IPPS and LTCH PPS fee-for-service policies have been extended.

Section 50204 – Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals

The Affordable Care Act and subsequent legislation provided for temporary changes to the low-volume hospital adjustment for fiscal years (FYs) 2011 through 2017. To qualify, the hospital must have less than 1,600 Medicare discharges and be located 15 miles or more from the nearest subsection (d) hospital. Section 50204 of the Bipartisan Budget Act of 2018 extends these temporary changes through FY 2018 (and provides for modified temporary changes through FY 2022).

Section 50205 - Extension of the Medicare-Dependent Hospital (MDH) Program -

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The Affordable Care Act and subsequent legislation had authorized the MDH program through September 30, 2017. Section 50205 Bipartisan Budget Act of 2018 extends the MDH program for discharges occurring on or after October 1, 2017, through FY 2022 (that is, for discharges occurring on or before September 30, 2022).

Section 51005 – Adjustments to the LTCH Site Neutral Payment Rate - Section 1206(a) of the Bipartisan Budget Act of 2013 established patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard Federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment. The Bipartisan Budget Act of 2013 provided for a transition period to the site neutral payment rate discharges occurring in cost reporting periods beginning in FY 2016 and FY 2017. Section 51005 of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH site neutral payment rate discharges that occur in cost reporting periods beginning in FY 2018 and FY 2019, and adjusts the site neutral payment rate by reducing the IPPS comparable amount by 4.6 percent for FYs 2018 through 2026.

To announce changes to the payment adjustment for low-volume hospitals and to the MDH program for FY 2018 in accordance with sections 50204 and 50205, respectively, of the Bipartisan Budget Act of 2018, CMS published a notice in the **Federal Register**, CMS-1677-N, on April 26, 2018, which can be found at

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

B. Policy:

1. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2018

The Affordable Care Act and subsequent legislation amended the low-volume hospital adjustment in section 1886(d)(12) of the Act by revising, for FYs 2011 through 2017, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. These specific amendments were extended until October 1, 2018, by section 50204 of the Bipartisan Budget Act of 2018. (Section 50204 of the Bipartisan Budget Act of 2018 also provides for an extension of temporary changes with certain modifications for FYs 2019 through FY 2022, which will be addressed separately).

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2018, in accordance with the existing regulations at §412.101(b)(2)(ii) and consistent with our implementation of the those changes in FYs 2011 and 2017, the Centers for Medicare and Medicaid Services (CMS) intends to publish a notice in the **Federal Register** updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2018. Implementation of the extension of this temporary change in the low-volume hospital payment adjustment for FY 2018 provided by section 50204 of the Bipartisan Budget Act of 2018 generally follows our established process that was used for FYs 2011 and 2017. (For additional information on our established process, refer to the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943))

Specifically, the number of Medicare discharges for purposes of the low-volume hospital adjustment for FY 2018 is determined in a manner consistent with how it was done for FY 2011 through FY 2017. During that time, the number of Medicare discharges used to establish the discharge criterion and the applicable low-volume percentage adjustment for qualifying hospitals were determined by Table 14, a list of IPPS hospitals with fewer than 1,600 Medicare discharges and their number of Medicare discharges according to the most recent available data published in the corresponding IPPS/LTCH PPS final rule. In the case of FY 2018, the corresponding most recent available data at the time we developed the FY 2018 IPPS/LTCH final rule was the March 2017 update of the FY 2016 Medicare Provider Analysis and Review (MedPAR) file. A file that lists the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files, (MAC Implementation File 6) can be found on the CMS website on the FY 2018 MAC Implementation Files webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html. (We note, in conjunction with the notice CMS-1677-N, CMS issued CMS-1677-N Table 1 (in lieu of Table 14 of the FY 2018 IPPS/LTCH PPS final rule), which also lists the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files. CMS-1677-N Table 1 can be found on the FY 2018 Final Rule Tables webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html.)

In order to facilitate administrative implementation, consistent with our historical practice, the only source that CMS and the Medicare Administrative Contractors (MACs) will use to determine the number of Medicare discharges for purposes of the low-volume adjustment for FY 2018 is the data from the March 2017 update of the FY 2016 MedPAR file. We note, CMS-1677-N Table 1 (and MAC Implementation File 6) is a list of IPPS hospitals with fewer than 1,600 Medicare discharges and is <u>not</u> a listing of the hospitals that qualify for the low-volume adjustment for FY 2018, since it does not reflect whether or not the hospital meets the mileage criterion (that is, generally the hospital must also be located more than 15 road miles from any other subsection (d) hospital). **In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2018 discharges, a hospital must meet both the discharge and mileage criteria.**

In order to receive a low-volume adjustment for FY 2018, consistent with our previously established process (described in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943)), CMS is continuing to

require a hospital to provide written notification to its MAC. Such notification must contain sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria so that the MAC can determine if the hospital qualifies as a low-volume hospital in accordance with existing requirements set forth in the regulations at § 412.101(b)(2)(ii) (in conjunction with § 412.101(e) as applicable). Under this procedure, a hospital receiving the low-volume hospital payment adjustment in FY 2017 may continue to receive a low-volume hospital payment adjustment in FY 2018 without reapplying if it continues to meet both the discharge criterion and the mileage criterion applicable for FY 2018. Such a hospital must send written verification stating that it continues to meet the applicable mileage criterion applicable for FY 2018.

A hospital's written notification must be received by its MAC no later than May 29, 2018, as stated in the notice CMS-1677-N, published in the **Federal Register** on April 26, 2018, that announced the updated discharge data source (as mentioned above). If a hospital's request for low-volume hospital status for FY 2018 is received after this date, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the low-volume hospital payment adjustment to determine the payment for the hospital's FY 2018 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For discharges occurring during FY 2018, if a hospital qualifies as a low-volume hospital, the low-volume hospital indicator field on the Provider Specific File (PSF) (position 74 – temporary relief indicator) must contain a value of 'Y' and the 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. (For hospitals that meet both the discharge criterion and the mileage criterion applicable for FY 2018, the value for the low-volume payment adjustment factor field can be found in MAC Implementation File 6, which is available on the FY 2018 MAC Implementation Files webpage as described above. As noted above, this value can also be found in CMS-1677-N Table 1 available on the FY 2018 Final Rule Tables webpage.) 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. Any hospital that does not meet either the discharge or mileage criteria is not eligible to receive a low-volume payment adjustment for FY 2018, and the MAC must update the low-volume hospital indicator field on the PSF (position 74 – temporary relief indicator) to hold a value of "blank".

The applicable low-volume hospital adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, Indirect Medical Education (IME) and outliers. For Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs), the applicable low-volume percentage increase is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

2. Extension of the Medicare-Dependent Hospital (MDH) Program

Under section 3124 of the Affordable Care Act, the MDH program authorized by section 1886(d)(5)(G) of the Act was set to expire at the end of FY 2012. These amendments were extended through September 30, 2017, by subsequent legislation. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program, through September 30, 2022. CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in the regulations at §412.108. (For additional information, refer to the FY 2016 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final Rule with Comment (IFC) (August 17, 2015; 80 FR 49594 through 49597))

a. Medicare-Dependent Hospital (MDH) Classification in States with No Rural Area

In addition to extending the MDH program, section 50205 of the Bipartisan Budget Act of 2018 also provides for hospitals that are located in a state without a rural area (i.e., an all-urban state) to be eligible to qualify for MDH status if in general it otherwise satisfies any of the statutory criteria to be reclassified as rural. Prior to the Bipartisan Budget Act of 2018, hospitals could only qualify for MDH status if they were

geographically in a rural area or if they reclassified as rural under the statutory provision that is codified in the regulations at 42 CFR 412.103. Under current regulations, hospitals located in all-urban states cannot reclassify as rural because their states do not have rural areas into which they can reclassify. This precluded hospitals in all-urban states from being classified as MDHs. The newly added provision in the Bipartisan Budget Act of 2018 allows hospitals in all-urban states to be eligible for MDH classification if, among the other criteria, it would have qualified for rural reclassification by meeting the criteria at § 412.103(a)(1) or (3) or the criteria at § 412.103(a)(2) as of January 1, 2018, for the sole purposes of qualifying for MDH classification, notwithstanding its location in an all-urban state.

Hospitals in all-urban states looking to qualify for MDH classification should submit the following:

1. Apply to their Regional Office as per the application requirements outlined at 42 CFR 412.103(b) to determine if they meet the qualifications for rural reclassification other than being located in an all-urban state.
2. Submit its request for MDH status to its MAC as per the classification procedures under 42 CFR 412.108(b) (the requirements of which are detail below).

A hospital in an all-urban state that qualifies as an MDH under the newly-added statutory provision will not be considered as having reclassified as rural but only as having satisfied one of the criteria at section 1886(d)(8)(E)(ii)(I), (II), or (III) (as of January 1, 2018, as applicable) for purposes of MDH classification.

b. Reinstatement of MDH Status

Consistent with our implementation of previous extensions of the MDH program, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective October 1, 2017, with no need to reapply for MDH classification. There are two exceptions:

i. ***MDHs that classified as SCHs on or after October 1, 2017***

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by September 1, 2017, (that is, 30 days prior to the expiration of the MDH program), to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of October 1, 2017. Additionally, some hospitals that had MDH status as of the October 1, 2017, expiration of the MDH program may have missed the September 1, 2017, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than October 1, 2017.

ii. ***MDHs that requested a cancellation of their rural classification under §412.103(b)***

In order to meet the criteria to become an MDH, generally a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at §412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2017. All other former MDHs will be automatically reinstated as MDHs effective October 1, 2017. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at §412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (§412.108(b)(2)).

2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (§412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (§412.108(b)(4)).

The existing Provider Type field on the PSF (position 55 – Provider Type) must be updated by the MAC to hold a value of "14" or "15" (as applicable) if the provider was classified as an MDH as of the date of September 30, 2017, expiration of the MDH provision. Any hospital classified as an SCH on or after October 1, 2017, or that requested a cancellation of their rural classification under §412.103(b) would not be automatically reinstated with MDH classification as of October 1, 2017, and the MAC must update the Provider Type field on the PSF (position 55 – Provider Type) to hold a value of "00" or "07" (as applicable).

c. Cancellation of MDH status

As required by the regulations at §412.108(b)(5), contractors must "**evaluate on an ongoing basis**" whether or not a hospital continues to qualify for MDH status.

Therefore, as required by the regulations at §412.108(b)(5) and (6), the MACs shall ensure that the hospital continues to meet the MDH criteria at §412.108(a) and shall notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2017, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

d. MAC Implementation Files

In conjunction with this CR, we have published files to assist the MACs in implementing the requirements of this CR. These files can be found in MAC Implementation File 5 available on the FY 2018 MAC Implementation Files webpage at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html

The following attachments will be available in **MAC Implementation File 5**:

1. Attachment 1, outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario.
2. Attachment 2 contains a listing with the following data for all providers that were classified as MDHs at the time the MDH provision expired. This list reflects the best available data at the time of the MDH provision expiration (i.e., October 1, 2017). MACs shall confirm that the information is accurate and complete.
3. Attachment 3 contains a draft letter with text corresponding to the scenarios outlined in Attachment 1. Each MAC shall add to each letter, information specific to that provider regarding how it is affected by the MDH program extension; that is, notifying the provider of its status under the extension of the MDH program. The status of each former MDH will either be:

- MDH status not reinstated; additional action required by the provider in order to be classified as an MDH. Provider must request a cancellation of SCH status or submit a request for rural classification under §412.103. Provider will then have to reapply for MDH status in accordance with the regulations under §412.108(b).

- MDH status reinstated and then subsequently cancelled due to the provider not continuing to meet the criteria for MDH classification under the requirements at §412.108(b)(5).

Notification to CMS

The contractor shall take appropriate action as described above for each provider in the listing for which they are responsible. The contractor shall then complete the listing for each provider and provide CMS with the following data:

a. CCN/Provider number

b. Provider name

c. Medicare Contractor

d. Notification sent to provider? Select Yes/No from drop down list

e. Action taken – Select appropriate action taken from the drop down list

f. & g. Dates if applicable

h. Explanation for action taken/comments

The completed listing shall be emailed to Shevi.Marciano@cms.hhs.gov by April 15, 2018.

Notification to Provider

Notification to providers is necessary only if there is a change that affects a provider's MDH status; that is, if the provider's MDH status is not reinstated seamlessly from October 1, 2017, because it falls within one of the two exceptions listed above or if the provider will lose its MDH status prospectively due to no longer meeting the criteria for MDH status, per the regulations at §412.108(b)(6).

Hospital Specific (HSP) Rate Update for MDHs

For the payment of FY 2018 discharges occurring on or after October 1, 2017, the Hospital Specific (HSP) amount for MDHs in the PSF will continue to be entered in FY 2012 dollars. The Pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and apply all updates and other adjustment factors to the HSP amount for FY 2013 and beyond.

3. Changes to the LTCH Site Neutral Payment Rate

Section 51005(a) of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH PPS site neutral payment rate cases provided by §1886(m)(6)(B)(i) of the Act to discharges occurring in cost reporting periods beginning in FY 2018 and FY 2019. Section 51005(b) of the Bipartisan Budget Act of 2018 reduces the "IPPS comparable amount" component of the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Act by 4.6 percent for FYs 2018 through 2026.

a. Extension of the blended payment rate for LTCH site neutral payment rate cases

The blended payment rate for LTCH site neutral payment rate cases is determined by the LTCH PPS Pricer according to the Federal PPS Blend Indicator variable in the PSF (data element 18, file position 75) so that providers with a value of '6' or '7' are paid a blend of 50 percent of the LTCH standard Federal payment rate payment and 50 percent of the site neutral payment rate payment, while providers with a value of '8' in the Federal PPS Blend Indicator variable in the PSF are paid 100 percent of the site neutral payment rate

payment.

To implement the extension of the blended payment rate provided by section 51005(a) of the Bipartisan Budget Act of 2018, we are revising the description of the Federal PPS Blend Indicator variable in the PSF for a value of '7' to indicate 50 percent of the site neutral payment rate and 50 percent of the LTCH standard Federal payment rate effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018 or FY 2019 (i.e., Blend Years 2 through 4).

In order to ensure site neutral payment rate for discharges in cost reporting periods beginning in FY 2018 (i.e., beginning on or after October 1, 2017 and before October 1, 2018), MACs shall update the Federal PPS Blend Indicator variable as follows:

6 – Blend Year 1 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2016 (on or after 10/01/2015 through 09/30/16)

7 - Blend Years 2 through 4 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018 or FY 2019

8 – Transition Blend no longer applies with cost reporting periods beginning in FY 2020 (on or after 10/01/2019)

Therefore, MACs shall ensure that the Federal PPS Blend Indicator variable in the PSF is updated to a value of '7' for any providers with a cost reporting period beginning on or after October 1, 2017, and as such currently have a value of '8' in the Federal PPS Blend Indicator variable in the PSF with an effective date of the fiscal year begin date for the cost reporting period.

b. Adjustment to the LTCH Site Neutral Payment Rate Cases

As provided by §1886(m)(6)(B) of the Act, the site neutral payment rate is the lesser of 100 percent of the estimated cost of the case or the "IPPS comparable amount". Section 51005 (b) of the Bipartisan Budget Act of 2018 adjusts the "IPPS comparable payment" component under the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Act (described in § 412.522(c)(1)(i)) in each of FYs 2018 through 2026. Specifically, section 51005(b) reduces the "IPPS comparable amount" component of the site neutral payment rate by 4.6 percent. (We note this 4.6 percent reduction applies to any applicable outlier payments under § 412.522(c)(1)(i), as well, and is applied after the application of the site neutral payment rate high cost outlier budget neutrality factor under § 412.522(c)(2)(i).)

In order to implement this adjustment, Pricer logic has been updated to reflect this reduction to the "IPPS comparable amount" component of the site neutral payment rate for discharges occurring in FY 2018.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10547.1	CMS shall update the IPPS and LTCH Pricers.									IPPS Pricer, LTCH Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10547.1.1	Medicare contractors shall pay claims with the updated IPPS and LTCH PPS Pricers issued with this CR.	X				X				
10547.2	Medicare contractors shall update the Provider Specific File (PSF), Position 74, Temporary Relief, with a 'Y' for those IPPS hospitals that meet both the discharge and mileage criteria for a low-volume hospital within 2 weeks of receiving the hospital's notification.	X								
10547.2.1	Medicare contractors shall update the PSF with an effective date of October 1, 2017, for those hospitals that had low-volume hospital status on September 30, 2017, and continue to meet the low-volume hospital discharge and mileage criteria.	X								
10547.3	Medicare contractors shall update the PSF, File Position 55, Provider Type, with a 14 or 15 for those IPPS hospitals that qualify as a MDH for discharges on or after October 1, 2017, with an effective date of October 1, 2017.	X								
10547.3.1	Medicare contractors shall confirm that the data in Attachment 2 is accurate and complete and forward to Shevi.Marciano@cms.hhs.gov by April 15, 2018.	X								
10547.3.2	Medicare contractors shall notify impacted IPPS hospitals with the letter in Attachment 3.	X								
10547.4	Medicare contractors shall reprocess IPPS and LTCH PPS claims impacted by this CR with a discharge date on or after October 1, 2017, through the implementation of the April, 2018 IPPS and LTCH PPS Pricers within 180 days of the implementation date of this change request.	X								
10547.5	Medicare contractors shall change the Federal PPS Blend Indicator (data element 18, file position75) in the Provider Specific File (PSF) to a '7' for an LTCH that currently has a value of '8'.	X								
10547.6	Medicare contractors shall update the Federal PPS Blend Indicator (data element 18, file position75) in the Provider Specific File (PSF) with a value of '8' for cost reporting periods beginning in FY20.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10547.7	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@cms.hhs.gov , Shevi Marciano, shevi.marciano@cms.hhs.gov , Maria Navarro, maria.navarro@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Addendum A - Provider Specific File

(Rev.4046, Issued: 05-10-18, Effective: 10-01-17, Implementation: 04-02-18)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
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<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
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<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 OSCAR number 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). Eff. 10/1/12, this provider type is no longer valid. 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). Eff. 10/1/12, this provider type no longer valid. 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

Data Element	File Position	Format	Title	Description
				34 Reserved 35 Hospice 36 Home Health Agency 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 OSCAR number (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

Data Element	File Position	Format	Title	Description
				8 Mountain 9 Pacific **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.

Data Element	File Position	Format	Title	Description
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. Eff. 10/1/12, MDHs are no longer valid provider types.
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.

Data Element	File Position	Format	Title	Description
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). *Effective the start of the hospital's FY 2018 cost reporting period through the start of the hospital's cost reporting period beginning on or after October 1, 2019 (FY 2020), code a 'S' for an LTCH that meets the provisions of section 15009 of 21st Century Cures Act.*
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002.

Data Element	File Position	Format	Title	Description
				LTCH PPS: Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002 *and before 10/01/2015.* 1 – Federal % 20 – Facility% 80 2 – Federal % 40 – Facility% 60 3 – Federal % 60 – Facility% 40 4 – Federal % 80 – Facility% 20 5 – Federal % 100 – Facility% 00 ***LTCH PPS:*** *Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015.* *6 – Blend Year 1 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY16 (on or after 10/01/2015 through 09/30/16)* *7 - Blend Year 2 through 4 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY17, FY18 or FY19* *8 – Transition Blend no longer applies with cost reporting periods beginning in FY20 (on or after 10/01/2019)* **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 – Federal % 50 – Facility% 50 3 – Federal % 75 – Facility% 25 4 – Federal % 100 – Facility% 00

Data Element	File Position	Format	Title	Description
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. Note that effective 10/1/12, MDHs are no longer valid provider types.
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 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.

Data Element	File Position	Format	Title	Description
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.)
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.

Data Element	File Position	Format	Title	Description
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.
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

Data Element	File Position	Format	Title	Description
				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 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. 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, or DSH adjustments. 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.
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.

Data Element	File Position	Format	Title	Description
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.
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

Data Element	File Position	Format	Title	Description
				"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 amount calculated and published by CMS for each hospital
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 and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital.
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-310	X(47)	Filler	