CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3373	**Date: October 14, 2015**
	Change Request 9253

Transmittal 3360, dated September 24, 2015, is being rescinded and replaced by Transmittal 3373 dated October 14, 2015 to reference the correction notice in the Policy section, reformat Attachment 4 to minimize the number of pages and update the 'Note' in Step 5 of Attachment 8. In addition, this Transmittal is no longer sensitive. All other information remains the same.

SUBJECT: Fiscal Year (FY) 2016 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2016 update to the IPPS and LTCH PPS. This Recurring Update Notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2015

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	3/20.3.4/Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond
R	3/40.2.4/IPPS Transfers Between Hospitals
R	3/Addendum A/Provider Specific File
R	3/20.2.3.1/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
Manual Instruction

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3373	Date: October 14, 2015	Change Request: 9253

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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 2016.

B. Policy: The following policy changes for FY 2016 were displayed in the Federal Register on July 31, 2015, with a publication date of August 17, 2015 and in the correction notice that appeared in the Federal Register on October 5, 2015. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2015 through September 30, 2016, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2015, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2015 through September 30, 2016. The new revised Pricer program shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

IPPS FY 2016 Update

A. FY 2016 IPPS Rates and Factors

Refer to Table 1 in Attachment 1.

B. PRICER Logic Changes

Pricer now applies the rural floor wage index policy to the Puerto Rico specific wage index for Puerto Rico providers. It compares each Puerto Rico provider's Puerto Rico specific CBSA wage index to the rural Puerto Rico Core Based Statistical Area (CBSA) (" 4*") wage index. If the rural Puerto Rico specific wage index is higher than the provider's Puerto Rico specific CBSA wage index, Pricer uses the rural Puerto Rico specific wage index for the provider. To ensure this new logic works correctly, contractors/MACs must send the rural Puerto Rico CBSA " 4*" records to IPDRVXXX for all Puerto Rico providers.

C. 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 33.0, software package effective for discharges on or after October 1, 2015. 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 33.0 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, 2015.

For discharges occurring on or after October 1, 2015, the Fiscal Intermediary Standard System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should receive the GROUPER documentation in early August 2015.

For discharges occurring on or after October 1, 2015, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should receive the MCE documentation in early August 2015. Note that the MCE version continues to match the Grouper version.

CMS created the following new MS-DRGs:

- MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC)
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC)

CMS deleted the following MS-DRGs:

- MS-DRG 237 (Major Cardiovascular Procedures with MCC) and
- MS-DRG 238 (Major Cardiovascular Procedures without MCC)

D. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2016 have been evaluated against the general post-acute care transfer policy criteria using the FY 2014 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review the following MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- 273 and 274 (Percutaneous Intracardiac Procedures with and without MCC, respectively)

See Table 5 of the FY 2016 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs. Click on the following link: 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 2016 IPPS Final Rule Home Page” or “Acute Inpatient Files for Download”.

E. New Technology Add-On

The following items will *continue* to be eligible for new-technology add-on payments in FY 2016:

1. Name of Approved New Technology: Argus

- Maximum Add on Payment: $72,028.75
- Identify and make new technology add-on payments with ICD-10-PCS procedure code 08H005Z or 08H105Z

2. Name of Approved New Technology: Kcentra

- Maximum Add on Payment: $1,587.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure code 30283B1
- Do not make this payment if one of the following diagnosis codes are on the bill: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, D68.4

3. Name of Approved New Technology: MitraClip® System

- Maximum Add on Payment: $15,000
- Identify and make new technology add-on payments with ICD-10-PCS procedure code 02UG3JZ

4. Name of Approved New Technology: RNS® System

- Maximum Add on Payment: $18,475
- Identify and make new technology add-on payments with ICD-10-PCS procedure code 0NH00NZ in combination with 00H00MZ

The following items will be eligible for new-technology add-on payments in FY 2016:

5. 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

6. 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

F. 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 2016, 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 2016 IPPS/LTCH PPS final rule and is also displayed in Table 2 in Attachment 1.

G. FY 2016 Wage Index Changes and Issues

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

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

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS adopted a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This transition adjustment will expire effective October 1, 2015, and is not applicable in FY 2016. In addition, 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 is assigning a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

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.*

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).

H. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103

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)).

I.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.

J. 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.

K. 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.

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

For FY 2016, 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 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

M. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2016

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 2016, 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 2016, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2015 update of the FY 2014 MedPAR file. Attachment 9 is the corrected Table 14 of the FY 2016 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/FY2016-IPPS-Final-Rule-Home-Page.html) and lists the "subsection (d)" ' hospitals with fewer than 1,600 Medicare discharges based on the March 2015 update of the FY 2014 MedPAR file and their low-volume hospital payment adjustment for FY 2016 (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. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion.

To receive a low-volume hospital payment adjustment under § 412.101 for FY 2016, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2015, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2015. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2015 may continue to receive a low-volume hospital payment adjustment for FY 2016 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2016 (as shown in corrected Table 14 of the FY 2016 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, 2015, 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 2016 is received after September 1, 2015, 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 2016 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

The MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria.

The MAC is to notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as low-volume hospitals and the effective date of the determinations for FY 2016 by November 16, 2015. The notification may be sent via e-mail to Michele.Hudson@cms.hhs.gov and Maria.Navarro@cms.hhs.gov, and should include the hospital's name, CMS certification number (CCN), address (street, city, state and zip code), the distance to the nearest IPPS hospital (as well as that hospital's address: street, city, state and zip code), the number of Medicare discharges from Table 14 of the FY 2016 IPPS/LTCH PPS final rule, and the effective date of the low-volume hospital determination. For low-volume hospital requests received after November 1, 2015, A/B MACs shall notify CMS Central Office as above within 15 days of the determination.

For discharges occurring during FY 2016, 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'. To implement this, the Pricer will apply the applicable low-volume hospital payment percentage adjustment shown in the corrected Table 14 of the FY 2016 IPPS/LTCH PPS final rule 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 2015 but no longer meets the low-volume hospital definition for FY 2016, and therefore, the hospital is no longer eligible to receive a low-volume hospital payment adjustment in FY 2016, 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 low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), IME and outliers. For SCHs and

MDHs, the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

N. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following Web site: www.qualitynet.org. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the 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 2016 under the Hospital Inpatient Quality Reporting (IQR) Program will be forthcoming in a TDL.

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

O. 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). HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC Reduction Program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year.

The HAC Reduction Program adjustment amount (that is, the 1-percent payment reduction) is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, new technology, readmissions, VBP, low-volume hospital payments, and capital payments. This amount will be displayed in the HAC PAYMENT AMT field in the IPPS PRICER output record. For SCHs and MDHs, the HAC Reduction Program adjustment amount applies to either the Federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

A list of providers subject to the HAC Reduction Program for FY 2016 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.

P. 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 2016 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§ 412.160 through § 412.162).

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute .The applicable percent for payment reductions for FY 2016 is 1.75 percent. This percent is gradually increasing each fiscal year from 1.0 in FY 2013 to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary. CMS calculates a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function' s slope, as well as an individual hospital' s TPS, the hospitals' own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

For FY 2016 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 2016. CMS expects to post the value-based incentive payment adjustment factors for FY 2016 in the near future in Table 16B of the FY 2016 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/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Tables.html. (MACs will receive subsequent communication when value-based incentive payment adjustment factors for FY 2016 in Table 16B are available.)

Upon receipt of this file, the claims processing contractors 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 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.

Q. Hospital Readmissions Reduction Program

For FY 2016, the readmissions adjustment factor is the higher of a ratio or 0.97 (-3 percent). The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount" that is, the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the reduction amount under the Hospital Readmissions Reduction Program. Add-on payments for IME, DSH (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor. For FY 2016, the portion of a MDH's payment reduction due to excess readmissions that is based on 75 percent difference between payment under the hospital-specific rate and payment under the Federal rate will be determined at cost report settlement. Consequently, in determining the claim payment, the PRICER will continue to only apply the readmissions adjustment factor to a MDH's wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable) to determine the payment reduction due to

excess readmissions.

The readmissions payment adjustment factors for FY 2016 are in Table 15 of the FY 2016 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/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Tables.html. Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2016 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2016, 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, 2015.

- If a provider has a readmissions adjustment factor on Table 15, then Medicare contractors 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, then Medicare contractors 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 2016) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15. Therefore, MACs followed the instructions in the second bullet above for the PSF for these hospitals.

R. 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 the Medicare DSH hospitals was finalized in the FY 2016 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 2016. 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 (FY2012-2014). CMS is issuing a Correction Notice to the FY 2016 IPPS final rule, which changes each provider's uncompensated care payment per claim amounts. Attachment 3 includes the updated estimated per discharge uncompensated care payment amounts per claim to be used for updating the PSF, which will be displayed in the corrected Medicare DSH Supplemental Data File for the Corrected Notice to the FY 2016 IPPS Final rule on the CMS website. 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 finalized in the Correction Notice to the FY 2016 IPPS Final Rule will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

The hospitals that were located in urban counties that are becoming rural under our adoption of the new OMB delineations, are subject to a transition for their Medicare DSH payment. For a hospital with more than 99 beds and less than 500 beds that was redesignated from urban to rural, it would be subject to a DSH payment adjustment cap of 12 percent. Under the transition, per the regulations at §412.102, for the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one-third of the difference between DSH payment before its redesignation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its redesignation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its redesignation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural. This adjustment will be determined at cost report settlement. In determining the claim payment, the PRICER will only apply the DSH payment adjustment based on its urban/rural status according to the redesignation.

S. 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. MS-DRGs 266 and 267 (Endovascular Cardiac Valve Replacement with MCC and Endovascular Cardiac Valve Replacement without MCC, respectively) were inadvertently omitted from the list of MS-DRs subject to the policy for FY 2015, therefore they are being added to the list with an effective date retroactive to October 1, 2014.

For FY 2016, MS-DRGs 237 and 238 (Major Cardiovascular Procedures with MCC and without MCC, respectively) will be deleted. The following MS-DRGs will be added:

- MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC)
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC)

The complete list of MS-DRGs subject to the IPPS policy for replaced devices offered without cost or with a credit and their effective and termination dates is displayed in CR9121.

LTCH PPS FY 2016 Update

A. FY 2016 LTCH PPS Rates and Factors

FY 2016 LTCH PPS Rates and Factors are located in Table 4 in Attachment 1.

The LTCH PPS Pricer has been updated with the Version 33.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2015, and on or before September 30, 2016.

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. This revision to payments under the LTCH PPS established a dual -rate paym e structure, under which discharge are paid either based on:

- The LTCH PPS standard Federal payment rate (i.e., generally consistent with the payment amount determined under the LTCH PPS prior to the amendments made by Public Law 113–67) for LTCH cases meeting the specified patient criteria upon discharge; or

- The site neutral payment rate (i.e., the lesser of an "IPPS-comparable" payment amount determined under § 412.529(d)(4), including a high cost outlier payment under §412.525(a) as applicable, or 100 percent of the estimated cost of the case as determined under § 412.529(d)(2)) for those cases not the meeting specified patient criteria upon discharge.

In order to be paid at the LTCH PPS standard Federal rate amount, the following criteria must be met:

- The discharge must not have not have a principal diagnosis in the LTCH of a psychiatric diagnosis or rehabilitation as indicated by the grouping of the discharge into one of 15 "psychiatric and rehabilitation" MS-LTC-DRGs (i.e., MS-LTC-DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897, 945, and 946).

- The discharge must have been immediately preceded by an IPPS hospital discharge ("immediately preceded" is defined as the LTCH admission occurring within one day of the IPPS hospital discharge based on the admission date on the LTCH discharge claim and the discharge date on the IPPS hospital claim).

- The patient discharged from the LTCH must have spent 3 days in the ICU during the immediately preceding IPPS hospital stay (discharges meeting this criteria will be identified by the use of revenue center codes 020x and 021x on the IPPS hospital discharge claim) <u>or</u> have received at least 96 hours of respiratory ventilation services during the LTCH stay (which will generally be identified by the use of ICD-10-PCS procedure code 5A1955Z on the LTCH claim).

The site neutral payment rate amount will be paid for patients discharged from the LTCH that do not meet the above criteria.

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). Information on the requirements implementing the application of the site neutral payment rate can be found in CR 9015.

Existing LTCH PPS policies, such as the short-stay outlier (SSO) policy (for discharges paid the LTCH PPS standard Federal rate) and the Interrupted Stay policy, will continue to apply in determining the applicable payment amount (i.e., site neutral payment rate or standard Federal payment rate) under the LTCH PPS.

2. Transition Blended Payment Rate for FYs 2016 and 2017

Public Law 113-67 establishes a transitional payment method site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017. 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. Under new § 412.522(c)(1), the site neutral payment rate is the lower of the IPPS comparable per diem amount determined under § 412.529(d)(4), including any applicable outlier payments under § 412.525(a), or 100 percent of the estimated cost of the case determined under § 412.529(d)(2). For purposes of the blended payment rate, the payment rate that would otherwise be applicable had the provisions of Public Law 113-67 not been enacted is the LTCH PPS standard Federal payment determined under § 412.523 (i.e., the LTCH PPS standard Federal payment rate that is applicable to discharges that meet the criteria for exclusion from the site neutral payment rate under new § 412.522(a)(2)).

Under the blended payment rate at § 412.522(c)(3), for LTCH discharges occurring in cost reporting periods beginning on or after October 1, 2015, and on or before September 30, 2017 (that is, discharges occurring in cost reporting periods beginning during FYs 2016 and 2017), the portions of the payment amounts determined under § 412.522(c)(1) (the site neutral payment rate) and under § 412.523 (the LTCH PPS standard Federal rate) include any applicable adjustments, such as HCO payments, as applicable, consistent with the requirements under § 412.523(d). For example, the portion of the blended payment for the discharge that is based on the site neutral payment rate includes 50 percent of any applicable site neutral payment rate HCO payment under our revised HCO payment policy under § 412.525(a). Similarly, the portion of the blended payment for the discharge that is based on the LTCH PPS standard Federal payment rate includes any applicable HCO payment under existing § 412.525(a).

3. Subclause (II) LTCHs

In the FY 2015 IPPS Final Rule, CMS established a payment adjustment under the LTCH PPS at §412.526 for hospitals "classified under subclause (II) of subsection (d)(1)(B)(iv)" of the Act (referred to as "subclause (II) LTCHs), effective for cost reporting periods beginning on or after October 1, 2014 (that is, Federal FY 2015 and beyond). Under this payment adjustment, payments to subclause (II) LTCHs are adjusted so that their LTCH PPS payments are generally equivalent to an amount determined under the reasonable cost-based reimbursement rules for both operating and capital-related costs. Consequently, the application of the site neutral payment rate at § 412.522 is not applicable to subclause (II) LTCHs. Currently there is only one hospital meeting the statutory definition of a subclause (II) LTCH, which is located in New York. The FY 2016 LTCH PPS Pricer includes logic to determine the claim payment amount for discharges from the subclause (II) LTCH that does not include the application of the site neutral payment rate in accordance with these policies.

B. Average Length Of Stay Calculation

Consistent with the amendments made by Public Law 113–67, beginning with cost reporting periods starting on or after October 1, 2015, for LTCHs which were classified as such by December 10, 2013, Medicare Advantage (MA) discharges and discharges paid the site neutral payment rate will not be included in the calculation of an LTCH's average length of Stay (ALOS) for the purposes of a hospital's payment classification as an LTCH under §412.23(e). All other requirements for calculating an LTCH's ALOS remain unchanged.

C. Discharge Payment Percentage

For all LTCHs' FY 2016 or later cost reporting periods, the statute requires LTCHs to be notified of their "discharge payment percentage" (DPP). The DPP 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. The LTCH's total number of LTCH PPS discharges for a cost reporting period and discharges which were paid at the LTCH PPS standard Federal payment rate are to be determined at cost report settlement using data from the PS&R. (Additional information regarding the identification of the discharge counts used in this calculation is forthcoming.) To calculate the DPP, divide the number of discharges paid at the LTCH PPS standard Federal payment rate by total LTCH PPS discharges. The percent equivalent of that result is the DPP. MACs shall provide notification to the LTCH of its DPP upon final

settlement of the cost report, beginning with cost reporting periods beginning on or after October 1, 2015. MACs may use the form letter in Attachment 2 to notify LTCHs of their discharge payment percentage. (Note, consistent with the 'special treatment' of 'subclause (II) LTCHs' (discussed in section A.3. above), MACs do not need to calculate or provide notification to subclause (II) LTCHs of their DPP upon final settlement of the cost report.)

D. LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2016, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year. MACs will receive more information under separate cover.

E. Provider Specific File (PSF)

The PSF required fields for all provider types which require a PSF can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update all applicable fields for LTCHs effective October 1, 2015, or effective with cost reporting periods that begin on or after October 1, 2015, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8C contains the FY 2016 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost outlier payments. Table 8C is available on the Internet at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices.html. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2015, Statewide average CCRs are used in the following instances:

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

2. LTCHs with a total CCR is in excess of 1.335 (referred to as the total CCR ceiling).

3. Any hospital for which data to calculate a CCR is not available.

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

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

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2016, and are the same COLAs established in the FY 2014 IPPS/LTCH PPS final rule. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2015, can be found in the FY 2016 IPPS/LTCH PPS final rule and is also shown in Table 2 in Attachment 1.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9253.1	Medicare contractor shall install and pay claims with the FY 2016 IPPS Pricer for discharges on or after October 1, 2015.					X				
9253.2	Medicare contractor shall install and pay claims with the FY 2016 LTCH Pricer for discharges on or after October 1, 2015.					X				
9253.3	Medicare contractor shall install and edit claims with the MCE version 33.0 and Grouper version 33.0 software with the implementation of the FY 2016 October quarterly release.					X				
9253.4	Medicare contractor shall establish yearly recurring hours to allow for updates to the list of ICD-10-CM diagnosis codes that are exempt from reporting Present on Admission (POA). **NOTE:** The list of ICD-10-CM diagnosis codes exempt from reporting POA.are displayed on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html.					X				
9253.5	Medicare contractors shall inform the QIO of any new hospital that has opened for hospital quality purposes.	X								
9253.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 7, 2015.	X								
9253.6.1	Medicare contractors shall update the PSF for CBSA and special wage index changes per the policy sections of this CR.	X								
9253.7	Medicare contractors shall notify CMS Central Office - Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as a low-volume hospital and the effective date of the determination for discharges **occurring in FY 2016 by November 16, 2015** including IPPS hospitals that qualify as low-volume hospitals after September 1, 2015 through November 1, 2015. Contractors shall also notify CMS Central Office - Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro of IPPS hospitals that qualify as low-volume hospitals after November 1, 2015, within 15 days of the	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	determination.									
9253.7.1	Medicare contractors shall remove the 'Y' low-volume indicator in the PSF (position 74 - temporary relief indicator) for providers who no longer qualify as a low volume provider.	X								
9253.8	Medicare contractors shall be aware of any manual updates included within this CR.	X								
9253.9	The CWF shall update edit and IUR 7272 for the post acute DRGs listed in Table 5 of the IPPS Final Rule.								X	
9253.10	For each LTCH's cost reporting period beginning on or after October 1, 2015, 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								
9253.10.1	For each LTCH's cost reporting period beginning on or after October 1, 2015, at settlement of such cost reporting period contractors shall inform LTCHs in writing of their discharge payment percentage.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9253.11	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	X				

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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, cami.digiacomo@cms.hhs.gov , Sarah Shirey-Losso, sarah.shirey-losso@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: 9