CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3431	**Date: December 29, 2015**
	Change Request 9253

Transmittal 3373, dated October 14, 2015, is being rescinded and replaced by Transmittal 3431 to add CardioMEMS™ HF Monitoring System to the list of items approved for a New Technology Add-On Payment and to renumber the list. 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: 3431	Date: December 29, 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: CardioMEMS™ HF Monitoring System

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

4. 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

5. 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:

6. 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

7. 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 payme 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) or 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.

<u>B. Average Length Of Stay Calculation</u>

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.

<u>C. Discharge Payment Percentage</u>

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	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 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 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 , 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

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

20.2.3.1 - Provider-Specific File
(Rev. 3431, Issued: 12-29-15, Effective: 10-01-15, Implementation: 10-05-15)

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. *Updates are published annually or quarterly, as needed, to notify A/B MACs of any changes to payment systems requiring updates to the PSF.*

The *A/B MACs* maintain the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the *A/B MAC* prepares an additional record showing the effective date. For example, when a hospital's FY beginning date changes as a result of a change in ownership or other "good cause," the *A/B MAC* makes an additional record showing the effective date of the change.

The format and data required by the PRICER program and by the provider-specific file is found in Addendum A.

The *A/B MACs* submit a file of provider-specific payment data to CMS CO every three months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), SNFs, and hospices, including those in Maryland. Regional home health *A/B MACs (HH)* submit a file of provider specific data for all home health agencies. *A/B MACs* serving as the audit *A/B MAC* for hospital based HHAs do not submit a file of provider specific data for HHAs.

The *A/B MACs* create a new record any time a change occurs for a provider. Data must be reported for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within seven business days after the end of the period being reported.

NOTE: *A/B MACs* submit the latest available provider-specific data for the entire reporting period to CO by the seven-business day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period, the *A/B MAC* may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, the *A/B MAC* may exclude the October 1 CO-required changes from the file submitted by October 9. The *A/B MAC* includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A. PPS Hospitals

The *A/B MACs (A)* submit all records (past and current) for all PPS providers every three months. Duplicate the provider file used in the "PRICER" module of the claims processing system.

B. Non-PPS Hospitals and Exempt Units

The *A/B MACs (A)* create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every three months. Code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file.

C. Hospice

The *A/B MACs (A)* create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all hospices. Data elements 33 and 38 are optional and may be populated if needed.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

D. Skilled Nursing Facility (SNF)

The *A/B MACs (A)* create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998.
The *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all SNFs. Data elements 33 and 38 are required if there is a special wage index. Effective October 1, 2005, through September 30, 2006, data elements 33 and 38 are required since there is a special wage index.

E. Home Health Agency (HHA)

The *A/B MACs (HH)* create a provider specific history file using the following data elements for each HHA. Regional home health *A/B MACs (HH)* submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

F. Inpatient Rehabilitation Facilities (IRFs)

The *A/B MACs (A)* create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 18, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all IRFs. Data elements 17, 33, 38, and 49 are required if applicable to the IRF.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

G. Long Term Care Hospital (LTCH)

The *A/B MACs (A)* create a provider specific history file using the following data elements for each LTCH beginning with their first cost reporting period that starts on or after October 1, 2002. *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 18, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

Effective July 1, 2005, data element 35 is required. Data elements 33 and 38 are optional and may be populated if needed. Data elements 12, 13, and 14 are no longer applicable.

Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

H. Inpatient Psychiatric Facilities (IPF)

The *A/B MACs (A)* create a provider specific history file using the following data elements for each IPF beginning with their first cost reporting period that starts on or after January 1, 2005.

The *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 17, 18, 19, 21, 22, 23, 25, 33, 35, 38, and 48 are required. All other data elements are optional for this provider type. Although data element 25 refers to the operating cost to charge ratio, ensure that both operating and capital cost-to-charge ratio are entered in data element 25 for IPFs. Ensure that data element 21 (Facility Specific Rate) will be determined using the same methodology to determine the interim payment per discharge under the TEFRA system.

Effective July 1, 2006, data element 13 is no longer required. Data elements 33 and 38 are optional and may be populated if needed.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

NOTE: All data elements, whether required or optional, must have a default value of “0” (zero) if numerical, or a blank value if alphanumerical.

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. *A/B MACs* must set up an NDM transfer from the *A/B MACs* system for which it is responsible. It is critical that the provider specific data is copied to the CMS Data Center using the following input data set names ("99999" should be changed to the *A/B MAC’s* 5-digit number):

Data set Name ---COPY TO: --MU00.@FPA2175.intermediary99999

DCB=(HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)

Data set Name ---RUN JOB: --MU00.@FPA2175.CLIST(intermediary99999)

See **Addendum A** for the Provider Specific File record layout and description.

20.3.4 – Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond

(Rev. 3431, Issued: 12-29-15, Effective: 10-01-15, Implementation: 10-05-15)

The IPPS changes for FY 2004 were published in the Federal Register on August 1, 2003. All changes are effective for hospital discharges occurring on or after October 1, 2003. Additional changes were listed in a Correction Notice to the Federal Register on October 6, 2003, and a One Time Notification (Pub. 100-20, Transmittal 16, published on October 31, 2003).

Fiscal year changes to the inpatient prospective payment system occur every October. Specific instructions will be published shortly after the publication of the IPPS Final Rule each year. *In addition, other changes to the inpatient prospective payment system may occur in January, April or July as necessary.*

40.2.4 – IPPS Transfers Between Hospitals

(Rev. 3431, Issued: 12-29-15, Effective: 10-01-15, Implementation: 10-05-15)

A3-3610.5, HO-415.8

A discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred from the hospital where the patient was admitted to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established. The following procedures apply. See §20.2.3 for proper Pricer coding to ensure that these requirements are met.

Note: CMS established Common Working File Edits (CWF) edits in January 2004 to ensure accurate coding and payment for discharges and/or transfers.

A – Transfers Between IPPS Prospective Payment Acute Care Hospitals

For discharges occurring on or after October 1, 1983, when a hospital inpatient is discharged to another acute care hospital, as described in 42 CFR 412.4(b), payment to the transferring hospital is based upon a graduated per diem rate (i.e., the prospective payment rate divided by the geometric mean length of stay for the specific MS-DRG into which the case falls; hospitals receive twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount). If the stay is less than l day, l day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. However, this day does not count against the patient's Medicare days (utilization days), since this Medicare day is applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital (see §40.1.D). If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate. Payment is made to the final discharging hospital at the full prospective payment rate.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage index values and any other adjustments are those that are appropriate for each hospital. Where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-DRG in the transferring hospital, payment to each is based upon the MS-DRG under which the patient was treated. For transfers on or after October 1, 1984, the transferring hospital may be paid an outlier payment. For further information on outlier payments for transfer cases, see section 20.1.2.4 of this manual.

An exception to the transfer policy applies to MS-DRG 789. The weighting factor for this MS-DRG assumes that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into this MS-DRG is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

Effective for discharges on or after October 1, 2003, patients who leave against medical advice (LAMA), but are admitted to another inpatient PPS hospital on the same day as they left, will be treated as transfers and the transfer payment policy will apply.

B – Transfers from an IPPS Acute Care Hospital to Hospitals or Hospital Units Excluded from the IPPS

When patients are transferred to hospitals or units excluded from IPPS, the full inpatient prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs or is made at the rate of its respective payment system (see exceptions in paragraph C of this section).

A transfer payment is made to the transferring hospital when patients are transferred to a hospital that would ordinarily be paid under prospective payment, but that is excluded because of participation in a state or area wide cost control program. Also, a transfer payment is made where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS and certain hospitals that are excluded from IPPS. These include:

- An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program (Patient Status Code 02)

- A critical access hospital (Patient Status Code 66)

C – Postacute Care Transfers
(Previously Special 10 DRG Rule)

For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying Postacute MS-DRGs referenced in paragraph (D) of this section and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under subpart B of 42 CRF 412). Facilities excluded from IPPS are inpatient rehabilitation facilities and units (Patient Status Code *62*), long term care hospitals (Patient Status Code *63*), psychiatric hospitals and units (Patient Status Code 65), children's hospitals, and cancer hospitals (Patient Status Code 05).

- To a skilled nursing facility (Patient Status Code 03).

- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (Patient Status Code 06).

Specific transfer cases under this paragraph qualify for payment under an alternative methodology. These include transfer cases in which the patient's discharge is assigned, as described in 42 CFR 412.4(f)(2), (f)(5) and (f)(6), to one of the qualifying Special Pay MS-DRGs referenced in paragraph (D) of this section. For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

D – Qualifying MS-DRGs

Refer to Table 5 of the applicable Fiscal Year IPPS Federal Register for the list of qualifying Postacute MS-DRGs and Special Pay Postacute MS-DRGs.

Addendum A - Provider Specific File

(Rev. 3431, Issued: 12-29-15, Effective: 10-01-15, Implementation: 10-05-15)

Data Element	File Position	Format	Title	Description
1	1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character NPI number.

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<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:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the 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>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>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</td></tr>
</table>

Data Element	File Position	Format	Title	Description
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).
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

Data Element	File Position	Format	Title	Description
				(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 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).

Data Element	File Position	Format	Title	Description
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **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.
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
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. 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 **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
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

Data Element	File Position	Format	Title	Description
				count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
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.

Data Element	File Position	Format	Title	Description
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
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 as of FY92.
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
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Standardized Amount Location CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code)

Data Element	File Position	Format	Title	Description
				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.
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:

Data Element	File Position	Format	Title	Description
				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.
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

Data Element	File Position	Format	Title	Description
				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 "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	*252-260*	*X(9)*	*Filler*	