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Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

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Related Change Request (CR) Number: 10869
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Related CR Transmittal Number: R4144CP
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by acute care and Long-Term Care Hospitals (LTCHs).

PROVIDER ACTION NEEDED

Change Request (CR) 10869 implements Fiscal Year (FY) 2019 policy changes for the Inpatient Prospective Payment System (IPPS) and LTCH PPS. Failure to adhere to these new policies could affect payment of Medicare claims. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a 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 Medicare to implement a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS makes updates to these prospective payment systems annually. CR10869 outlines those changes for FY 2019.

IPPS FY 2019 Update

The following list of policy changes for FY 2019 were displayed in the Federal Register on August 2, 2018, with a publication date of August 17, 2018, and in the corresponding correction document published on October 3, 2018 in the Federal Register. The Federal Register and CR10869 covers all items in more depth and are effective for hospital discharges occurring on

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or after October 1, 2018, through September 30, 2019, unless otherwise noted. New IPPS and LTCH PPS Pricer software packages were released prior to October 1, 2018, that include updated rates that are effective for claims with discharges occurring on or after October 1, 2018, through September 30, 2019. The MACs installed the new revised Pricer programs timely to ensure accurate payments for IPPS and LTCH PPS claims.

Files for download listed throughout CR10869 are available on the CMS website. MACs used the following links for files for download and hospitals may find this information helpful:

- FY 2019 Final Rule Tables webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Tables.html
- FY 2019 Final Rule Data Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Data-Files.html
- MAC Implementation Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY-2019-MAC-Implementation-Files.html

Alternatively, the files on the webpages listed above are also available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, “FY 2019 IPPS Final Rule Home Page” or the link titled “Acute Inpatient--Files for Download” (and select ‘Files for FY 2019 Final Rule and Correction Notice’).

IPPS FY 2019 Update

A. FY 2019 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2019 IPPS/LTCH PPS Final Rule, available on the FY 2019 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, High Cost Outlier (HCO) threshold, and Cost-of-Living Adjustment (COLA) factors, refer to MAC Implementation Files 1 available on the FY 2019 MAC Implementation Files webpage.

B. Medicare Severity -Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new International Classification of Diseases Tenth Edition (ICD-10) MS-DRG Grouper, Version 36.0, software package effective for discharges on or after October 1, 2018. 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 36.0, 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, 2018.

For discharges occurring on or after October 1, 2018, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date

For discharges occurring on or after October 1, 2018, the MCE selects the proper internal code edit tables based on discharge date. Note that the MCE version continues to match the Grouper version. CMS increased the number of MS-DRGs from 754 to 761 for FY 2019. CMS is implementing 18 new MS‑DRGs for FY 2019 and deleting 11 MS-DRGs.

FY 2019 New MS-DRGs

- MS-DRG 783 Cesarean Section with Sterilization with MCC
- MS-DRG 784 Cesarean Section with Sterilization with CC
- MS-DRG 785 Cesarean Section with Sterilization without CC/MCC
- MS-DRG 786 Cesarean Section without Sterilization with MCC
- MS-DRG 787 Cesarean Section without Sterilization with CC
- MS-DRG 788 Cesarean Section without Sterilization without CC/MCC
- MS-DRG 796 Vaginal Delivery with Sterilization/D&C with MCC
- MS-DRG 797 Vaginal Delivery with Sterilization/D&C with CC
- MS-DRG 798 Vaginal Delivery with Sterilization/D&C without CC/MCC
- MS-DRG 805 Vaginal Delivery without Sterilization/D&C with MCC
- MS-DRG 806 Vaginal Delivery without Sterilization/D&C with CC
- MS-DRG 807 Vaginal Delivery without Sterilization/D&C without CC/MCC
- MS-DRG 817 Other Antepartum Diagnoses with O.R. Procedure with MCC
- MS-DRG 818 Other Antepartum Diagnoses with O.R. Procedure with CC
- MS-DRG 819 Other Antepartum Diagnoses with O.R. Procedure without CC/MCC
- MS-DRG 831 Other Antepartum Diagnoses without O.R. Procedure with MCC
- MS-DRG 832 Other Antepartum Diagnoses without O.R. Procedure with CC
- MS-DRG 833 Other Antepartum Diagnoses without O.R. Procedure without CC/MCC

FY 2019 Deleted MS-DRGs

- MS-DRG 685 Admit for Renal Dialysis
- MS-DRG 765 Cesarean Section with CC/MCC
- MS-DRG 766 Cesarean Section without CC/MCC
- MS-DRG 767 Vaginal Delivery with Sterilization and/or D&C
- MS-DRG 774 Vaginal Delivery with Complicating Diagnosis
- MS-DRG 775 Vaginal Delivery without Complicating Diagnosis
- MS-DRG 777 Ectopic Pregnancy
- MS-DRG 778 Threatened Abortion
- MS-DRG 780 False Labor
- MS-DRG 781 Other Antepartum Diagnoses with Medical Complications
- MS-DRG 782 Other Antepartum Diagnoses without Medical Complications

CMS revised the titles to the following MS-DRGs for FY 2019:

MS-DRG Revised Title Descriptions for FY2019

- MS-DRG 11 Tracheostomy For Face, Mouth & Neck Diagnoses Or Laryngectomy With MCC
- MS-DRG 12 Tracheostomy For Face, Mouth & Neck Diagnoses Or Laryngectomy With CC
- MS-DRG 13 Tracheostomy For Face, Mouth & Neck Diagnoses Or Laryngectomy Without CC/MCC
- MS-DRG 16 Autologous Bone Marrow Transplant With CC/MCC Or T-Cell Immunotherapy
- MS-DRG 864 Fever And Inflammatory Conditions
- MS-DRG 207 Respiratory System Diagnosis With Ventilator Support>96 Hours Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)
- MS-DRG 291 Heart Failure & Shock With MCC Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)
- MS-DRG 296 Cardiac arrest, unexplained w MCC Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)
- MS-DRG 870 Septicemia Or Severe Sepsis With MV >96 Hours Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)

See the ICD-10 MS-DRG V36.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V36 manual at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html for the complete list of FY 2019 ICD-10 MS-DRGs and Medicare Code Edits.

C. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2019 have been evaluated against the general post-acute care transfer policy criteria using the FY 2017 MedPAR data according to the regulations under Sec. 412.4(c). As a result of this review no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy. However, MS-DRGs 023 (Craniotomy with Major Device Implant or Acute CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator) and 024 (Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis without MCC or Chemotherapy Implant or Epilepsy with Neurostimulator) were added to the special payment policy list.

See Table 5 of the FY 2019 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2019 Final Rule Tables.

CMS notes that implementation of the inclusion of discharges to hospice care as a post-acute care transfer subject to the payment adjustments beginning in FY 2019, as required by Section 53109 of the Bipartisan Budget Act of 2018, was addressed in Change Request 10602 (Transmittal 2094; June 20, 2018).

D. New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2019:

1. Name of Approved New Technology: Defitelio®

- Maximum Add-on Payment: $80,500 (Note, this amount has been updated for FY 2019)
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 or XW04392

2. Name of Approved New Technology: ZINPLAVA™

- Maximum Add-on Payment: $1,900
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033A3 or XW043A3

3. Name of Approved New Technology: Stelara®

- Maximum Add-on Payment: $2,400
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: XW033F3

The following items are eligible for new-technology add-on payments in FY 2019:

1. Name of Approved New Technology: VYXEOS™

- Maximum Add-on Payment: $36,425
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033B3 or XW043B3

2. Name of Approved New Technology: Remedē® System

- Maximum Add-on Payment: $17,250
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 0JH60DZ and 05H33MZ in combination with procedure code: 05H03MZ or 05H43MZ

3. Name of Approved New Technology: GIAPREZA™

- Maximum Add-on Payment: $1,500
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033H4 or XW043H4

4. Name of Approved New Technology: AndexXa™

- Maximum Add-on Payment: $14,062.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03372 or XW04372

5. Name of Approved New Technology: Sentinel® Cerebral Protection System™

- Maximum Add-on Payment: $1,400
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: X2A5312

6. Name of Approved New Technology: Aquabeam®

- Maximum Add-on Payment: $1,250
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: XV508A4

7. Name of Approved New Technology: VABOMERE™

- Maximum Add-on Payment: $5,544
- Identify and make new technology add-on payments with an NDC of 70842012001 or 65293000901 (VABOMERE™ Meropenem-Vaborbactam Vial)

8. Name of Approved New Technology: ZEMDRI™ (Plazomicin)

- Maximum Add-on Payment: $2,722.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033G4 or XW043G4

9. Name of Approved New Technology: Kymriah®/Yescarta®

- Maximum Add-on Payment: $186,500
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033C3 or XW043C3

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

There are no changes to the COLA factors for FY 2019. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2018, is available in the FY 2019 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2019 MAC Implementation Files webpage.

F. Wage Index Changes and Issues

1. New CBSA
In OMB Bulletin No. 17–01, OMB announced that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Area. As discussed in the FY 2019 final rule, effective for FY 2019 new urban CBSA is as follows:

- Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho.

2. Section 505 Hospitals (Out-Commuting Adjustment**)**

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the "outmigration adjustment," is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under § 412.103, or redesignated under Section 1886(d)(8)(B) of the Act.

G. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act and Certain Urban Hospitals Reclassified as Rural Hospitals Under Section 412.103

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. The list of hospitals that have waived Lugar status for FY 2019 is available on the FY 2019 MAC Implementation File webpage.

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 Disproportionate Share Hospitals (DSH) adjustment since these hospitals are considered rural under the capital PPS (see § 412.320(a)(1)).

H. Multicampus Hospitals

1. Wage Index

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multi-campus 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 Provider Specific File (PSF), to identify and denote a sub-campus 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 is noted in the PSF. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

2. Qualification for Certain Special Statuses

In the FY 2019 Final rule, CMS codified its current policies regarding how multi-campus hospitals may qualify for special status as a Sole-Community Hospital (SCH), Rural Referral Center (RRC), Medicare-Dependent Hospital (MDH), and rural reclassification under § 412.103.

Specifically, the main campus of a hospital cannot obtain a SCH, RRC, or MDH status or rural reclassification independently or separately from its remote location(s), and vice versa. Rather, the hospital (the main campus and its remote location(s)) are granted the special treatment or rural reclassification as one entity if the criteria are met. To meet the criteria, combined data from the main campus and its remote location(s) are used where the regulations at § 412.92 for SCH, § 412.96 for RRC, § 412.103 for rural reclassification, and § 412.108 for MDH require data, such as bed count, number of discharges, or case-mix index, for example. Where the regulations require data that cannot be combined, specifically qualifying criteria related to location, mileage, travel time, and distance requirements, the hospital needs to demonstrate that the main campus and its remote location(s) each independently satisfy those requirements in order for the entire hospital, including its remote location(s), to be reclassified as rural or obtain a special status.

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

MACs will update the PSF by following the steps, in order, in Attachment 1 of CR10869 to determine the appropriate wage index and other payments.

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

For FY 2019, MACs must update the Hospital-Specific (HSP) amount in the PSF for all SCHs and MDHs. The HSP amount must be updated from FY 2012 dollars to FY 2018 dollars by applying an update factor of 1.04058 to the current HSP amount in the PSF before entering this final amount in the PSF with an effective date of 10/1/2018. The factor of 1.04058 represents the product of all of the annual market basket updates (that is, applicable percentage increases), the DRG budget neutrality factors for FYs 2012 through 2018, and the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480. PRICER will apply the update and DRG budget neutrality factor to the HSP amount for FY 2019.

K. Low-Volume Hospitals – Criteria and Payment Adjustments for FY2019

Section 50204 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) modified the definition of a low‑volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Specifically, Section 50204 amended the qualifying criteria for low‑volume hospitals to specify that, for FYs 2019 through 2022, a subsection (d) hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has less than 3,800 total discharges during the fiscal year. Section 50204 also amended the statute to provides that, for discharges occurring in FYs 2019 through 2022, the Secretary shall determine the applicable percentage increase using a continuous, linear sliding scale ranging from an additional 25 percent payment adjustment for hospitals with 500 or fewer discharges to 0 percent additional payment for hospitals with more than 3,800 total discharges in the fiscal year. A hospital's total discharges, which includes Medicare and non-Medicare discharges, is based on the hospital's most recently submitted cost report. The regulations implementing the hospital payment adjustment policy are at section 412.101.
For FY 2019, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2018, in order for the applicable low-volume

payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2018 (through September 30, 2019). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2018 may continue to receive a low-volume hospital payment adjustment for FY 2019 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2019. As in previous years, such a hospital had to send written verification that was received by its MAC no later than September 1, 2018, stating that it meets the mileage criterion applicable for FY 2019. If a hospital's request for low-volume hospital status for FY 2019 was received after September 1, 2018, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2019 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For FY 2019, for each qualifying hospital, MACs must determine the low-volume hospital payment adjustment using the hospital's total discharges in its most recently submitted cost report as of the time of the MAC's low-volume hospital status determination as follows:

- For hospitals with 500 or fewer total discharges, the adjustment is an additional 25 percent for each Medicare discharge.
- For hospitals with 501 and fewer than 3,800 total discharges, the adjustment for each Medicare discharge is an additional percent calculated using the formula: (95 / 330) – (number of total discharges / 13,200)

As noted above, "number of total discharges" includes Medicare and non-Medicare discharges and based on the hospital's most recently submitted cost report at the time of the hospital's low-volume hospital payment adjustment request.

L. 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. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2019 under the Hospital IQR Program is available in MAC Implementation File 3 available on the FY 2019 MAC Implementation Files webpage.

M. Hospital Acquired Condition Reduction Program (HAC)

The Hospital-Acquired Conditions (HAC) Reduction Program requires the Secretary of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing 25 percent of all subsection (d) hospitals with respect to HAC quality measures. Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (that is, the worst-performing quartile) will be subject to a 1 percent payment reduction. This payment adjustment applies to all Medicare discharges for that fiscal year.

CMS did not make the list of providers subject to the HAC Reduction Program for FY 2019 public in the final rule because hospitals had until August 2018 to notify CMS of any errors in the calculation of their Total HAC Score under the Scoring Calculations Review and Corrections

period. Updated hospital level data for the HAC Reduction Program will be made publicly available on the Hospital Compare website following the review and corrections process in January 2019.

N. Hospital Value Based Purchasing (VBP)

For FY 2019 CMS will implement the base operating MS-DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2019. CMS expects to post the final value-based incentive payment adjustment factors for FY 2019 in the near future in Table 16B of the FY 2019 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2019 IPPS/LTCH PPS Final Rule Tables webpage.

O. Hospital Readmissions Reduction Program (HRRP)

CMS expects to post the HRRP payment adjustment factors for FY 2019 in Table 15 of the FY 2019 IPPS/LTCH PPS final rule (which are available on the FY 2019 IPPS Final Rule Tables webpage). Hospitals that are not subject to a reduction under the HRRP in FY 2019 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2019, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

P. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, 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 the aggregate amount available for uncompensated care payments based on its share of total uncompensated care reported by Medicare DSH hospitals.

The Medicare DSH payment is 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 is applied in PRICER.

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2019 IPPS Final Rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2019. The Uncompensated Care Per Discharge Amount and Projected DSH Eligibility are located in the Medicare DSH Supplemental Data File for FY 2019, which are available on the FY 2019 Final Rule Data Files webpage.

For FY 2019, new hospitals with a CCN established after October 1, 2015 that are eligible for Medicare DSH will have their Factor 3 calculated at cost report settlement using uncompensated care costs reported on Line 30 of Worksheet S-10 as the numerator and a denominator of $30,210,112,106. Factor 3 is then applied to the total uncompensated care

payment amount finalized in the FY 2019 IPPS Final Rule to determine the total amount to be paid to the hospital. If a new hospital has a CCR on line 1 of Worksheet S-10 in excess of 0.93, MACs will contact Section3133DSH@cms.hhs.gov for further instructions on how to calculate the uncompensated care costs for the numerator. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as new. CMS notes it is possible that there are additional new hospitals during FY 2019 and therefore those would not be listed on the Medicare DSH Supplemental Date File. In the case of a new hospital in Puerto Rico, the hospital's Factor 3 would need to be calculated by the MAC based on cost report's Medicaid days, which may need to be annualized, plus 14% for SSI proxy, and then divided by denominator of 37,539,919.

Q. Recalled Devices

A hospital's IPPS payment is reduced, for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS- DRGs that were already on the list. There are no new MS-DRGs for FY 2019 subject to the policy for replaced devices offered without cost or with a credit.

LTCH PPS FY 2019 Update

A. FY 2019 LTCH PPS Rates and Factors

The FY 2019 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2019 Final Rule Tables webpage. Other FY 2019 LTCH PPS Factors are available in MAC Implementation File 2 on the FY 2019 MAC Implementation File webpage.

The LTCH PPS Pricer is updated with the Version 36.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2018, and on or before September 30, 2019.

B. Application of the Site Neutral Payment Rate

Section 1886(m)(6) of the Act establishes patient-level criteria for payments under the LTCH PPS for cost reporting periods beginning on or after October 1, 2015. LTCH discharges that do not meet the patient-level criteria are paid the site neutral payment rate. The application of the site neutral payment rate is codified in the regulations at § 412.522.

The statute originally established a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which was extended by subsequent legislation to cost reporting periods beginning during FY 2018 and FY 2019. 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. This transitional blended payment rate for site neutral

rate LTCH discharges is included in the Pricer logic.

Under Section 51005 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123), the IPPS comparable amount under the site neutral payment rate is reduced by 4.6 percent for FYs 2018 through 2026. This adjustment is included in the Pricer logic.

The temporary exception to the site neutral payment rate for certain severe wound discharges from certain LTCHs expires for cost reporting periods that begin on or after October 1, 2018.

C. The 25-Percent Threshold Policy

CMS eliminated the 25-percent threshold policy in the FY 2019 IPPS/LTCH PPS final rule, effective October 1, 2018. Accordingly, the regulations describing the 25-percent threshold policy at Section 412.538 have been removed and reserved.

D. LTCH Quality Reporting (LTCHQR) Program

Under the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, for FY 2019, 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.

E. Provider Specific File (PSF)

The PSF required fields for all provider types, which require a PSF are available in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 and Addendum A.

In OMB Bulletin No. 17–01, OMB announced that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Area. As discussed in the FY 2019 final rule, effective for FY 2019 new urban CBSA is as follows:

- Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho

Table 8C contains the FY 2019 Statewide average LTCH total Cost-to-Charge Ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2019 Final Rule Tables webpage. Per the regulations in 42 CFR Sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2019, 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 1.280 (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

There are no updates to the COLAs for FY 2019. The COLAs effective for discharges occurring on or after October 1, 2018 are available in the FY 2019 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2019 MAC Implementation Files webpage. (Note that the same COLA factors are used under the IPPS and the LTCH PPS for FY 2019.)

G. Discharge Payment Percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon final settlement of the cost report.

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital's target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2019 IPS/LTCH PPS final rule, CMS established an update to an extended neoplastic disease care hospital's target amount for FY 2018 of 2.9 percent.

ADDITIONAL INFORMATION

The official instruction, CR10869, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4144CP.pdf. If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
October 11, 2018	Initial article released.