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

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PROVIDER TYPE 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 short term acute care and Long-Term Care Hospitals (LTCHs).

PROVIDER ACTION NEEDED

Change Request (CR) 10547 provides information and implementation instructions for Sections 50204, 50205, and 51005 of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act of 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (see https://www.gpo.gov/fdsys/pkg/BILLS-115hr1892enr/pdf/BILLS-115hr1892enr.pdf). The new law includes the extension of certain provisions that had expired October 1, 2017. Specifically, the following Medicare Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS) fee-for-service policies have been extended.

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

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

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these temporary changes through FY 2018 (and provides for modified temporary changes through FY 2022).

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

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

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

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2018, in accordance with the existing regulations at Section 412.101(b)(2)(ii) (see https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1101) and consistent with implementation of the those changes in FYs 2011 and 2017, the Centers for Medicare & Medicaid Services (CMS) intends to publish a notice in the Federal Register updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2018. Implementation of the extension of this temporary change in the low-volume hospital payment adjustment for FY 2018 provided by Section 50204 of the Bipartisan Budget Act of 2018 generally follows the established process that was used for FYs 2011 and 2017. (For additional information on the established process, refer to the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943))

Specifically, the number of Medicare discharges for purposes of the low-volume hospital adjustment for FY 2018 is determined in a manner consistent with how it was done for FY 2011 through FY 2017. During that time, the number of Medicare discharges used to establish the discharge criterion and the applicable low-volume percentage adjustment for qualifying hospitals were determined by Table 14, a list of IPPS hospitals with fewer than 1,600 Medicare discharges and their number of Medicare discharges according to the most recent available data published in the corresponding IPPS/LTCH PPS final rule. In the case of FY 2018, the

corresponding most recent available data at the time CMS developed the FY 2018 IPPS/LTCH final rule was the March 2017 update of the FY 2016 Medicare Provider Analysis and Review (MedPAR) file.

A file that lists the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files (MAC Implementation File 6) is available on the FY 2018 MAC Implementation Files webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html. (CMS issued CMS-1677-N Table 1, a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files in conjunction with the notice in the **Federal Register** published on April 26, 2018, In lieu of Table 14 of the FY 2018 IPPS/LTCH PPS Final Rule. CMS-1677-N Table 1 is available on the FY 2018 Final Rule Tables webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html.)

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

In order to receive a low-volume adjustment for FY 2018, consistent with the previously established process (described in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943)), CMS is continuing to require a hospital to provide written notification to its MAC. Such notification must contain sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria so that the MAC can determine if the hospital qualifies as a low-volume hospital in accordance with existing requirements set forth in the regulations at Section 412.101(b)(2)(ii) (in conjunction with Section 412.101(e) as applicable). Under this procedure, a hospital receiving the low-volume hospital payment adjustment in FY 2017 may continue to receive a low-volume hospital payment adjustment in FY 2018 without reapplying if it continues to meet both the discharge criterion and the mileage criterion applicable for FY 2018. Such a hospital must send written verification stating that it continues to meet the applicable mileage criterion applicable for FY 2018.

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

discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For discharges occurring during FY 2018, if a hospital qualifies as a low-volume hospital, the low-volume hospital indicator field on the Provider Specific File (PSF) (position 74 – temporary relief indicator) must contain a value of 'Y' and the low-volume payment adjustment factor field on the PSF (positions 252-258) must contain a value greater than 0 and less than or equal to 0.250000. (For hospitals that meet both the discharge criterion and the mileage criterion applicable for FY 2018, the value for the low-volume payment adjustment factor field can be found in CMS-1677-N Table 1 as described above). To implement this, the Pricer will apply the applicable low-volume hospital payment adjustment factor from the PSF for hospitals that have a value of 'Y' in the low-volume hospital indicator field on the PSF. Any hospital that does not meet either the discharge or mileage criteria is not eligible to receive a low-volume payment adjustment for FY 2018, and the MAC must update the low-volume hospital indicator field on the PSF (position 74 – temporary relief indicator) to hold a value of "blank."

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

Extension of the MDH Program

Under Section 3124 of the Affordable Care Act, the MDH program authorized by the Social Security Act (§1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended through September 30, 2017, by subsequent legislation. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program, through September 30, 2022. CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in the regulations at §412.108 (see https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1108). (For additional information, refer to the FY 2016 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final Rule with Comment (IFC) (August 17, 2015; 80 FR 49594 through 49597))

MDH Classification in States with No Rural Area

In addition to extending the MDH program, Section 50205 of the Bipartisan Budget Act of 2018 also provides for hospitals that are located in a state without a rural area (that is, an all-urban state) to be eligible to qualify for MDH status if it otherwise satisfies any of the statutory criteria to be reclassified as rural. Prior to the Bipartisan Budget Act of 2018, hospitals could only qualify for MDH status if they were geographically in a rural area or if they reclassified as rural under the statutory provision that is codified in the regulations at 42 CFR 412.103 (see https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.

412_1103). Under current regulations, hospitals located in all-urban states cannot reclassify as rural because their states do not have rural areas into which they can reclassify. This precluded hospitals in all-urban states from being classified as MDHs. The newly added provision in the Bipartisan Budget Act of 2018 allows a hospital in an all-urban state to be eligible for MDH classification if, among the other criteria, it would have qualified for rural reclassification by meeting the criteria at § 412.103(a)(1) or (3) or the criteria at § 412.103(a)(2) as of January 1, 2018, notwithstanding its location in an all-urban state.

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

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

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

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

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

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

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2017. All other former MDHs will be

automatically reinstated as MDHs effective October 1, 2017. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at Section 412.108(b) require that:

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

Cancellation of MDH Status

As required by the regulations at Section 412.108(b)(5), MACs must "**evaluate on an ongoing basis**" whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at §412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at §412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the MAC provides written notification to the hospital.

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

Notification to Provider

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

Hospital Specific (HSP) Rate Update for MDHs

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

Changes to the LTCH Site Neutral Payment Rate

Section 51005(a) of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH PPS site neutral payment rate cases provided by the Social Security Act (§1886(m)(6)(B)(i)) to discharges occurring in cost reporting periods beginning in FY 2018 and

FY 2019. Section 51005(b) of the Bipartisan Budget Act of 2018 reduces the "IPPS comparable amount" component of the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act by 4.6 percent for FYs 2018 through 2026.

Extension of the Blended Payment Rate for LTCH Site Neutral Payment Rate Cases

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

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

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

> 6 – Blend Year 1 (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2016 (on or after 10/01/2015 through 09/30/16)
>
> 7 – Blend Years 2 through 4 (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018, or FY 2019
>
> 8 – Transition Blend no longer applies with cost reporting periods beginning in FY 2020 (on or after 10/01/2019)

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

Adjustment to the LTCH Site Neutral Payment Rate Cases

As provided by the Social Security Act (§1886(m)(6)(B)), the site neutral payment rate is the lesser of 100 percent of the estimated cost of the case or the "IPPS comparable amount." Section 51005 (b) of the Bipartisan Budget Act of 2018 adjusts the "IPPS comparable payment" component under the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act (described in Section 412.522(c)(1)(i)) (see https://www.ecfr.gov/cgi-bin/text-

idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1522) in each of FYs 2018 through 2026. Specifically, Section 51005(b) reduces the "IPPS comparable amount" component of the site neutral payment rate by 4.6 percent. (CMS notes this 4.6 percent reduction applies to any applicable outlier payments under §412.522(c)(1)(i), as well, and is applied after the application of the site neutral payment rate high cost outlier budget neutrality factor under Section 412.522(c)(2)(i).)

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

ADDITIONAL INFORMATION

The official instruction, CR10547, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4046CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
May 14, 2018	Initial article released.