CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4390	**Date: October 7, 2019**
	Change Request 11361

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 7, 2019. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2020 update to the IPPS and LTCH PPS. This Recurring Update Notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

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	3/20.1.2.1/Cost to Charge Ratios
R	3/20.1.2.5/Reconciliation
R	3/20.1.2.6/Time Value of Money
R	3/20.1.2.7/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/150.24/Determining the Cost-to-Charge Ratio
R	3/150.26/Reconciliation
R	3/150.28/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/Addendum A - Provider Specific File
R	4/250.5/Medicare Payment for Ambulance Services Furnished by Certain CAHs

III. FUNDING:
For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

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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. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually. This Change Request (CR) outlines those changes for FY 2020.

B. Policy: The following policy changes for FY 2020 went on display on August 2, 2019, and appeared in the Federal Register on August 16, 2019. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2019 through September 30, 2020, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2019, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2019 through September 30, 2020. The new revised Pricer program shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

Files for download listed throughout the CR are available on the CMS website. Medicare Administrative Contractors (MACs) shall use the following links for files for download on the following pages (when not otherwise specified):

- FY 2020 Final Rule Tables webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables.html
- FY 2020 Final Rule Data Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Data-Files.html
- MAC Implementation Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-MAC.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 2020 IPPS Final Rule Home Page” or the link titled “Acute

Inpatient--Files for Download" (and select 'Files for FY 2020 Final Rule').

IPPS FY 2020 Update

A. FY 2020 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 2020 IPPS/LTCH PPS Final Rule, available on the FY 2020 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 File 1 available on the FY 2020 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 Revision (ICD-10) MS-DRG Grouper, Version 37.0, software package effective for discharges on or after October 1, 2019. 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 37.0, 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, 2019.

For discharges occurring on or after October 1, 2019, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation in September 2019.

For discharges occurring on or after October 1, 2019, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should have received the MCE documentation in September 2019. Note that the MCE version continues to match the Grouper version.

CMS maintained the number of MS-DRGs at 761 for FY 2020. CMS is creating two new MS-DRGs and deleting two MS-DRGs for FY 2020.

FY 2020 New MS-DRGs

MS-DRG 319 Other Endovascular Cardiac Valve Procedures with MCC

MS-DRG 320 Other Endovascular Cardiac Valve Procedures without MCC

FY 2020 Deleted MS-DRGs

MS-DRG 691 Urinary Stones with ESW Lithotripsy with CC/MCC

MS-DRG 692 Urinary Stones with ESW Lithotripsy without CC/MCC

CMS revised the titles to the following MS-DRGs for FY 2020:

FY 2020 MS-DRG Revised Title Descriptions

MS-DRG 207 Respiratory System Diagnosis with Ventilator Support greater than 96 Hours

MS-DRG 266 Endovascular Cardiac Valve and Supplement Procedures with MCC

MS-DRG 267 Endovascular Cardiac Valve and Supplement Procedures without MCC

MS-DRG 291 Heart Failure and Shock with MCC

MS-DRG 296 Cardiac Arrest, Unexplained with MCC

MS-DRG 693 Urinary Stones with MCC

MS-DRG 694 Urinary Stones without MCC

MS-DRG 870 Septicemia or Severe Sepsis With MV greater than 96 Hours

See the ICD-10 MS-DRG V37.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V37 manual located on the MS-DRG Classifications and Software webpage (at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html) for the complete list of FY 2020 ICD-10 MS-DRGs and Medicare Code Edits.

C. Replaced Devices Offered without Cost or with a Credit

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.

For FY 2020, subject to the policy for replaced devices offered without cost or with a credit, new MS-DRG 319 and MS-DRG 320 (Other Endovascular Cardiac Valve Procedures with and without MCC, respectively) were created, the title for MS-DRG 266 was revised from “Endovascular Cardiac Valve Replacement with MCC” to “Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC” and the title for MS-DRG 267 was revised from “Endovascular Cardiac Valve Replacement without MCC” to “Endovascular Cardiac Valve Replacement and Supplement Procedures without MCC.

D. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2020 have been evaluated against the general post-acute care transfer policy criteria using the FY 2018 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 273 and 274 were removed from the list of MS-DRGs that are subject to the post-acute care transfer policy and the special payment policy.

See Table 5 of the FY 2020 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2020 Final Rule Tables webpage.

E. New Technology Add-On

Beginning FY 2020, the new technology add-on payment percentage under § 412.87 is increased to 65 percent, or to 75 percent for certain antimicrobials that are designated by the Food and Drug Administration (FDA) as a qualified infectious disease product (QIDP).

The following items will *continue* to be eligible for new-technology add-on payments in FY 2020:

1. Name of Approved New Technology: VYXEOS™

- Maximum Add-on Payment: $47,352.50
- 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: $22,425
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 0JH60DZ and 05H03MZ in combination with procedure code: 05H33MZ or 05H43MZ

3. Name of Approved New Technology: GIAPREZA™

- Maximum Add-on Payment: $1,950
- 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: $18,281.25
- 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: $1,820
- 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: $1,625
- 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: $8,316
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033N5 or XW043N5 **or** an NDC of 70842012001 **or** 65293000901 (VABOMERE™ Meropenem-Vaborbactam Vial)
- Technology is designated as a QIDP by the FDA.

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

- Maximum Add-on Payment: $4,083.75
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033G4 or XW043G4
- Technology is designated as a QIDP by the FDA.

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

- Maximum Add-on Payment: $242,450

- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033C3 or XW043C3

The following items are eligible for new-technology add-on payments in FY 2020:

1. Name of Approved New Technology: Azedra®

- Maximum Add-on Payment: $98,150
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033S5 or XW043S5

2. Name of Approved New Technology: T2 Bacteria Test Panel

- Maximum Add-on Payment: $97.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XXE5XM5

3. Name of Approved New Technology: ERLEADA™ (apalutamide)

- Maximum Add-on Payment: $1,858.25
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW0DXJ5

4. Name of Approved New Technology: Jakafi® (ruxolitinib)

- Maximum Add-on Payment: $3,977.06
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW0DXT5

5. Name of Approved New Technology: Xospata®

- Maximum Add-on Payment: $7,312.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW0DXV5

6. Name of Approved New Technology: CABLIVI® (caplacizumab)

- Maximum Add-on Payment: $33,215
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW013W5, XW033W5, or XW043W5

7. Name of Approved New Technology: Balversa™ (erdafitinib)

- Maximum Add-on Payment: $3,563.23
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW0DXL5

8. Name of Approved New Technology: Spravato™ (esketamine)

- Maximum Add-on Payment: $1,014.79
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 3E097GC

9. Name of Approved New Technology: Elzonris™

- Maximum Add-on Payment: $125,448.05
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033Q5 or XW043Q5

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

There are no changes to the COLA factors for FY 2020. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2019, can be found in the FY 2020 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2020 MAC Implementation Files webpage.

G. Updating the PSF for Wage Index, Reclassifications and Redesignations and Wage Index Changes and Issues

MACs shall update the PSF by following the steps, in order, in the file on the FY 2020 MAC Implementation File webpage, to determine the appropriate wage index and other payments.

For FY 2020 we made the following changes to the wage index:

- We removed urban to rural reclassifications from the calculation of the rural floor.
- Increased the wage index values for hospitals with a wage index value below the 25th percentile wage index value of 0.8457 across all hospitals,
- Apply a 5 percent cap for FY 2020 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2019.

These changes will be handled by Pricer except for certain hospitals that require MACs to calculate a wage index and use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38). As explained in CR 10273 (Transmittal 3885; October 17, 2017), effective October 1, 2018, unless otherwise instructed by CMS, MACs shall seek approval from the CMS central office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38). We refer the MAC to the FY 2020 MAC Implementation File webpage and the file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications" for complete details filling in the PSF regarding ALL circumstances related to the wage index.

H. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act and Certain Urban Hospitals Reclassified as Rural Hospitals Under § 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 2020 can be found on the FY 2020 MAC Implementation File webpage. Complete details on how to fill out the PSF for these hospitals are available on the FY 2020 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)).

I. Multicampus Hospitals

1. Wage Index

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 the FY 2020 MAC Implementation File webpage). 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 2020 in which a multicampus hospital with inpatient campuses located in different CBSAs is created, please contact Miechal.Kriger@cms.hhs.gov and Michael.Treitel@cms.hhs.gov for instructions.

2. Qualification for Certain Special Statuses

As explained in CR 10869 (Transmittal 4144; October 4, 2018), in the FY 2019 Final rule, CMS codified its current policies regarding how multicampus 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.

J. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospital (MDH) Program

Effective Date of SCH/MDH Status

As explained in CR 10869 (Transmittal 4144; October 4, 2018), for applications received on or after October 1, 2018, the effective date for MDH or SCH status is the date the MAC received the complete application (per revised § 412.108(b)(4) and § 412.92 (b)(2)(i)). An application is considered complete on the date the MAC received all supporting documentation needed to conduct the review.

K. Low-Volume Hospitals – Criteria and Payment Adjustments for FY2020

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 provide 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 at the time of the hospital's low-volume hospital payment adjustment request. The regulations implementing the hospital payment adjustment policy are at § 412.101.

For FY 2020, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2019, in order for the applicable low-volume payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2019 (through September 30, 2020). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2019 may continue to receive a low-volume hospital payment adjustment for FY 2020 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2020. As in previous years, such a hospital must send written verification that is received by its MAC no later than September 1, 2019, stating that it meets the mileage criterion applicable for FY 2020. If a hospital's request for low-volume hospital status for FY 2020 is received after September 1, 2019, 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 2020 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For FY 2020, 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 at the time of the hospital's low-volume hospital payment adjustment request 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.

For FY 2020 discharges, the Pricer will calculate the low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF using the adjustment factor value in the LV Adjustment Factor field on the PSF. Therefore, if a hospital qualifies for the low-volume hospital payment adjustment for FY 2020, the MAC must ensure the low-volume indicator field on the PSF (position 74 – temporary relief indicator) holds a value of 'Y'. For such hospitals, the MAC must also update the LV Adjustment Factor on the PSF (positions 252 - 258) to hold the value of the low-volume hospital payment adjustment factor (determined by the formula described above). Likewise, if a hospital qualified for the low-volume hospital payment adjustment for FY 2019 but no longer meets the low-volume hospital definition for FY 2020, and therefore the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective October 1, 2019, the MAC must update the low-volume indicator field to hold a value of 'blank' and update the LV Adjustment Factor on the PSF to hold a value of 'blank'.

L. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following Web site: https://protect2.fireeye.com/url?k=0fe7c33d-53b2caed-0fe7f202-0cc47a6a52de-baf7e91788487178&u=https://protect2.fireeye.com/url?k=d7e9fc21-8bbde55d-d7e9cd1e-0cc47adc5fa2-ef93c8aae9934c1e&u=http://www.qualitynet.org/. A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) for each hospital that will receive the quality initiative bonus. The field shall be left blank for hospitals that will receive the statutory reduction under the Hospital Inpatient Quality Reporting (IQR) Program. 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 2020 under the Hospital IQR Program are found in MAC Implementation File 3 available on the FY 2020 MAC Implementation Files webpage.

For new hospitals, A/B MACs shall enter a '1' in the PSF and provide information to the Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Support Contractor (SC) as soon as possible so that the Hospital Inpatient VIQR SC 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 Hospital Inpatient VIQR SC the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital IQR Program reporting requirements. The MACs shall provide this information monthly to the Hospital Inpatient VIQR SC. It shall include: State Code, Medicare Accept Date, Provider Name, Contact Name and email address (if available), Provider ID number, physical address, and Telephone Number.

M. Hospital Acquired Condition Reduction Program (HAC)

The Hospital-Acquired Condition (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 (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction. This payment adjustment applies to all Medicare fee-for-service discharges for that fiscal year.

We did not make the list of providers subject to the HAC Reduction Program for FY 2020 public in the final rule, because hospitals have until August 2019 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 in January 2020. If necessary, MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program in a Technical Direction Letter (TDL). Until CMS issues final values, contractors shall enter 'N' in the HAC Reduction Indicator field.

N. Hospital Value Based Purchasing (VBP)

For FY 2020 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 2020. CMS expects to post the final value-based incentive payment adjustment factors for FY 2020 in the near future in Table 16B of the FY 2020 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2020 IPPS/LTCH PPS Final Rule Tables webpage). (MACs will receive subsequent communication when value-based incentive payment adjustment factors for FY 2020 in Table 16B are available)

Upon receipt of this file, the MACs 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 FY 2020 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.

O. Hospital Readmissions Reduction Program (HRRP)

CMS expects to post the HRRP payment adjustment factors for FY 2020 in the near future in Table 15 of the FY 2020 IPPS/LTCH PPS final rule (which are available via the Internet on the FY 2020 IPPS Final Rule Tables webpage). (MACs will receive subsequent communication when the HRRP payment adjustment factors for FY 2020 in Table 15 are available.) Hospitals that are not subject to a reduction under the HRRP in FY 2020 (such as Maryland hospitals), have an HRRP payment adjustment factor of 1.0000. For FY 2020, hospitals should only have an HRRP payment adjustment factor between 1.0000 and 0.9700. (Note the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) field in the PSF refers to the HRRP payment adjustment factor.)

Upon receipt of this file, the MACs must update the Hospital Readmissions Reduction Program participant (HRR Indicator) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF with an effective date of October 1, 2019 as follows:

- If a provider has an HRRP payment adjustment factor on Table 15, MACs shall input a value of '1' in the HRR Indicator field and enter the HRRP payment adjustment factor in the HRR Adjustment field.
- If a provider is not listed on Table 15, MACs shall input a value of '0' in the HRR Indicator field and leave the HRR Adjustment field blank.

Until CMS issues final values, contractors shall enter '0' in the HRR Indicator field.

P. Medicare Disproportionate Share Hospital (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH payment methodology beginning in FY 2014. Under current law at section 1886(r) of the Act, hospitals receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH at section 1886(d)(5)(F) of the Act. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will be paid as uncompensated care payments 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 in PRICER to 25 percent of the amount the hospital previously would have received under the statutory formula. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment is applied in PRICER.

In the FY 2020 IPPS/LTCH PPS Final Rule, we finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount to be paid to Medicare DSH hospitals along with a total uncompensated care payment amount. Interim uncompensated care payments will continue to be paid on the claim as an estimated per claim amount to the hospitals that have been projected to receive Medicare DSH payments in FY 2020. The estimate Per Claim Amount and Projected DSH Eligibility for each Subsection (d) hospital and Subsection (d) Puerto Rico hospital are located in the Medicare DSH Supplemental Data File for FY 2020, which is available via the Internet on the FY 2020 Final Rule Data Files webpage.

MACs shall enter the updated estimated per claim uncompensated care payment amounts in data element 57 in the PSF from the FY 2020 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File, as described below. The interim estimated uncompensated care payments that are paid on a per claim basis will be reconciled at cost report settlement with the total uncompensated care payment amount displayed in the

Medicare DSH Supplemental Data File.

For FY 2020, new hospitals, that is hospitals with CCNs established after October 1, 2015, for uncompensated care payment purposes, that are determined to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the uncompensated care costs from the hospital's FY 2020 cost report, as reported on Line 30 of Worksheet S-10 (annualized, if needed) as the numerator. The denominator used for this calculation can be found in the FY 2020 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Then, Factor 3 is multiplied by the total uncompensated care payment amount finalized in the FY 2020 IPPS Final Rule to determine the total uncompensated care payment amount to be paid to the hospital, if the hospital is determined DSH eligible at cost report settlement. For FY 2020, Puerto Rico hospitals that do not have a FY 2013 report are considered new hospitals and would be subject to this new hospital policy, as well.

If a new hospital has a CCR on line 1 of Worksheet S-10 in excess of 1.082, 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. However, we note, it is possible that there will be additional new hospitals during FY 2020 and therefore those would not be listed on the Medicare DSH Supplemental Date File.

For FY 2020, newly merged hospitals, e.g. hospitals that have a merger during FY 2020, will have their interim uncompensated care payments reconciled at cost report settlement by the MAC. A Factor 3 for the merged hospital will be calculated based on annualizing both providers' uncompensated care data (Worksheet S-10 line 30) from FY 2015 cost report and combining under the surviving CCN.

Q. Outlier Payments

IPPS Statewide Average CCRs

Tables 8A and 8b contain the FY 2020 Statewide average operating and capital Cost-to-Charge ratios (CCRs) for urban and rural hospitals. Tables 8A and 8B are available on the FY 2020 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.84(i)(3)(iv)(C), for FY 2020, 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. Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with §412.8(b). For FY 2020, hospitals with an operating CCR in excess of 1.155 or a capital CCR in excess of 0.144 are assigned the appropriate statewide average CCR
3. Hospitals for whom the MAC obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 20.1.2.1 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

Additionally, for all hospitals, use of an operating and/or capital CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

Change to Only Require Contacting CMS by Email for Outlier Reconciliation Notification for IPPS and LTCH Hospitals

The Medicare Claims Processing Manual, Chapter 3 - Inpatient Hospital Billing instructs MACs to send notification to the Central Office via the following address and email address: CMS C/O Division of Acute Care- IPPS Outlier Team 7500 Security Blvd Mail Stop C4-08-06 Baltimore, MD 21244, and outliersIPPS@cms.hhs.gov for requests such as use of alternative data for a CCR, contacting CMS in the event of errors, and requests to reconcile outlier payments.

This CR is facilitating manual revisions so that MACs are no longer required to contact CMS via the mail address. This CR is revising Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, § 20.1.2.1, 20.1.2.5, 20.1.2.6, 20.1.2.7 for IPPS and § 150.24, 150.26, and 150.28 for LTCH to only require email notification via outliersipps@cms.hhs.gov.

Clarification to LTCH Outlier Reconciliation Determinations

As a result of the FY 2019 IPPS/LTCH PPS Final Rule (82 FR 38541 – 38542), short stay outliers (SSO) are no longer included in the outlier threshold or subject to reconciliation. Changes to the SSO payment methodology removed estimated cost as a consideration for payment to SSO cases. As a result, SSO payments are no longer subject to reconciliation. CMS revised paragraph (f) of § 412.529 to specify that SSO payments will be reconciled only for discharges occurring before October 1, 2017.

Accordingly, this CR is facilitating corresponding manual revisions to Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, § 150.26 to reflect the FY 2019 rule changes to LTCH short stay outlier payment policies.

MACs may contact CMS at outliersipps@cms.hhs.gov with questions, including questions about the correct PS&R fields to use based on the cost reporting period.

Removal of Sections No Longer Applicable

Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, § 20.1.2.5(B) for IPPS and § 150.26(B) for LTCH states that Medicare contractors shall have until April 25, 2011 to submit via email to outliersipps@cms.gov a list of providers that were flagged for outlier reconciliation prior to April 1, 2011. This CR is deleting §§ 20.1.2.5(B) and 150.26(B) because these sections no longer apply.

R. Change Related to CAH Payment for Ambulance Services

Prior to FY 2020, regulations stated payment for ambulance services furnished by a CAH or by an entity that was owned and operated by a CAH was 101 percent of the reasonable costs of the CAH or entity in furnishing those services, but only if the CAH or the entity was the only provider or supplier of ambulance services within a 35-mile drive of the CAH. If there was another provider or supplier of ambulance services located within a 35-mile drive of the CAH, the CAH was paid for its ambulance services using the Ambulance Fee Schedule. By "provider" of ambulance services we mean Medicare-participating providers that submit claims under Medicare for ambulance services (for example, hospitals, CAHs, skilled nursing facilities, and home health agencies). And by "supplier" of ambulance services we mean an entity that provides ambulance services and is independent of any Medicare-participating or non-Medicare-participating provider.

It was brought to our attention that there may be providers or suppliers of ambulance services that are located within a 35-mile drive of a CAH, that are not owned or operated by the CAH and are not legally authorized to transport people either to or from the CAH. For example, there could be a situation where an ambulance supplier is located within a 35-mile drive of a CAH, but in a different State, and the ambulance supplier does not have the appropriate state licensure to furnish ambulance services in the State where the CAH is located. Under this scenario, the regulations required that the CAH be paid for its ambulance services using the Ambulance Fee Schedule, which in general provides lower payment rates than reasonable cost-based payments, even though the out-of-state ambulance supplier cannot actually furnish ambulance

services to transport individuals either to or from the CAH.

We believed this outcome was inconsistent with the intent of the Medicare Rural Hospital Flexibility Program, which is to provide access to care for individuals living in remote and rural areas. As such, we proposed and finalized our proposal to interpret the statutory requirement that the CAH or the CAH-owned and operated entity be the only provider or supplier of ambulance services within a 35-mile drive of the CAH, to exclude consideration of ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals to or from the CAH. This policy change is effective for cost reporting periods beginning on or after October 1, 2019.

As a result of this FY 2020 IPPS/LTCH PPS Final Rule, particularly the change related to CAH Payment for Ambulance Services, this CR is facilitating corresponding manual revisions to Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §250.5, Medicare Payment for Ambulance Services Furnished by Certain CAHs.

LTCH PPS FY 2020 Update

A. FY 2020 LTCH PPS Rates and Factors

The FY 2020 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2020 Final Rule Tables webpage. Other FY 2020 LTCH PPS Factors can be found in MAC Implementation File 2 available on the FY 2020 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 37 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2019, and on or before September 30, 2020.

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, and MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date. MACs shall ensure that for cost reporting period beginning during FY 2018 or 2019, the blend year indicator is set to “7” and for cost reporting period beginning during FY 2020, the blend year indicator is set to “8”. **In particular, MACs shall ensure the blend year indicator is set to “8” beginning with each LTCH’s cost reporting period that begins on or after October 1, 2019.**

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.

C. 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 settlement of the

cost report. MACs may use the form letter available on the Internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html to notify LTCHs of their discharge payment percentage.

Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods beginning on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that is not at least 50 percent be informed of such a fact; and section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH's discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by section 1886(m)(6)(C)(iii) of the Act. CMS implemented this requirement in the FY 2020 IPPPS/LTCH PPS final rule and further information, including necessary Medicare claims processing systems changes, will be provided in a separate instruction.

D. LTCH Quality Reporting (LTCHQR) Program

Under the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, for FY 2020, 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 LTCH as needed, and update all applicable fields for LTCHs effective October 1, 2019, or effective with cost reporting periods that begin on or after October 1, 2019, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8C contains the FY 2020 Statewide average LTCH total Cost-to-Charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2020 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 2020, 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 in excess of 1.253 (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.

Additionally, for all LTCHs, use of a total CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

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

There are no updates to the COLAs for FY 2020. The COLAs effective for discharges occurring on or after October 1, 2019 can be found in the FY 2020 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2020 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2020.)

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 2020 IPPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2020 of 3.0 percent.

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	
11361.1	Medicare contractors shall install and pay claims with the FY 2020 IPPS Pricer for discharges on or after October 1, 2019.					X				
11361.2	Medicare contractors shall install and pay claims with the FY 2020 LTCH Pricer for discharges on or after October 1, 2019.					X				
11361.3	Medicare contractors shall install and edit claims with the MCE version 37.0 and Grouper version 37.0 software with the implementation of the FY 2020 October quarterly release.					X				
11361.4	Medicare contractors 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				
11361.5	Medicare contractors shall inform the Quality Improvement Organization (QIO) of any new hospital that has opened for hospital quality purposes.	X								
11361.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR prior to the implementation of the FY 2020 IPPS and LTCH Pricers.	X								
11361.6.1	Medicare contractors shall follow the instructions in the policy section and on the FY 2020 MAC Implementation File webpage to update the PSF and	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	ensure that the CBSA is assigned properly for all IPPS providers. **NOTE**: Medicare contractors must follow these instructions for the following: All current IPPS hospitals; any new hospitals that open during FY 2020; or any change of hospital status during FY 2020.									
11361.6.2	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no IPPS provider has an operating CCR or a capital CCR in the PSF that is in excess of the FY 2020 applicable IPPS CCR ceilings. Additionally, use of an operating and/or capital CCR of 0.0 requires approval from the CMS Central Office.	X								
11361.6.3	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no LTCH has a total CCR in the PSF that is in excess of the FY 2020 total CCR ceiling. Additionally, use of a total CCR of 0.0 requires approval from the CMS Central Office.	X								
11361.7	Medicare contractors shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.	X								
11361.8	For hospitals paid under the IPPS, Medicare contractors shall remove the 'Y' low-volume indicator in the PSF (position 74 - temporary relief indicator) and remove the LV Adjustment Factor (positions 252-258) for providers who no longer qualify as a low-volume hospital. For hospitals paid under the IPPS who qualify as a low-volume hospital for FY 2020, Medicare contractors shall ensure the low-volume indicator in the PSF holds a value of ‘Y’ and the LV Adjustment Factor holds the hospital’s applicable low-volume hospital adjustment factor as described in the IPPS policy section of this CR.	X								
11361.9	Medicare contractors shall be aware of any manual updates included within this CR.	X								
11361.10	The CWF shall update the edit and IUR 7272 as necessary for the post-acute DRGs listed in Table 5 of								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the IPPS Final Rule when changes are made. **NOTE**: There were no new DRGs added to the list of DRGs subject to the post-acute care transfer policy or the special payment policy listed in Table 5 in the FY 2020 IPPS Final Rule. However MS-DRGs 273 and 274 were removed from the list of DRGs subject to the post-acute care transfer policy or the special payment policy.									
11361.11	For each LTCH's cost reporting period beginning on or after October 1, 2019, 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								
11361.11.1	For each LTCH's cost reporting period beginning on or after October 1, 2019, at settlement of such cost reporting period contractors shall inform LTCHs in writing of their discharge payment percentage. An example letter for informing an LTCH of its discharge payment percentage can be found on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html	X								
11361.12	Unless otherwise instructed by CMS, MACs shall seek approval from the CMS Central Office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).	X								
11361.13	Medicare contractors shall hold all IPPS and LTCH PPS claims with dates of discharge on or after October 1, 2019 through October 21, 2019, until the successful implementation of the FY 2020 IPPS and LTCH PPS Pricers.	X								
11361.13.1	Medicare contractors shall apply payer only condition code 15 (Clean claim delayed in CMS' processing system) and release no more than twice the normal daily claim volume in one cycle (or stagger the release of claims if needed) when the Pricers have been installed into production.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11361.14	Medicare contractors shall be aware of updates to the Medicare Claims Processing Manual, Chapter 3, Sections 20.1.2.1, 20.1.2.5, 20.1.2.6, 20.1.2.7, 150.24, 150.26, and 150.28.	X								
11361.14.1	Medicare contractors shall contact CMS via email at outliersIPPS@cms.hhs.gov (and not mail hard copies) for matters outlined in Medicare Claims Processing Manual, Chapter 3, Sections 20.1.2.1, 20.1.2.5, 20.1.2.6, 20.1.2.7, 150.24, 150.26, and 150.28.	X								
11361.14.2	Medicare contractors shall follow the outlier reconciliation criteria clarifications for LTCHs in the Medicare Claims Processing Manual, Chapter 3, Section 150.26.	X								
11361.15	Medicare contractors shall be aware of updates to the Medicare Claims Processing Manual, Chapter 4, Section 250.5.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11361.16	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	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

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

VI. FUNDING

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

ATTACHMENTS: 0

20.1.2.1 - Cost to Charge Ratios

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

For discharges before August 8, 2003, Medicare contractors used the latest final settled cost report to determine a hospital's cost-to-charge ratios (CCRs). For those hospitals that met the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective for discharges occurring on or after August 8, 2003 Medicare contractors are to use alternative CCRs rather than one based on the latest settled cost report when determining a hospital's CCR (to download PM A-03-058, visit our Web site at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/CMS-Program-Memoranda. http://www.cms.hhs.gov/Transmittals/Downloads/A03058.pdf). For all other hospitals, effective October 1, 2003, Medicare contractors are to use CCRs from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs.

A. - Calculating a Cost-to-Charge Ratio

For IPPS outlier calculations, Medicare's portion of hospital costs is determined by using hospital specific cost-to-charge ratios (CCRs). At the end of the cost reporting period, the hospital prepares and submits a cost report to its Medicare contractor, which includes Medicare allowable costs and charges. The Medicare contractor completes a preliminary review of the as-submitted cost report and issue a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and an NPR is issued.

The Medicare contractor shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period).

Effective November 7, 2005, the following methodology shall be used to calculate a hospital's operating and capital CCRs.

Inpatient PPS Operating CCR

1) Identify total Medicare inpatient operating costs from the Medicare cost report, from Worksheet D-1, Part II, line 53. (If a positive amount is reported on line 42 for nursery costs, subtract this amount on line 42 from the amount on line 53).

2) Identify total Medicare inpatient operating charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS operating CCR by dividing the amount in step 1 by the amount in step 2.

Inpatient Capital CCR

1) Identify total Medicare inpatient capital cost from Worksheet D Part 1, column 10, sum of lines 25 through 30, plus column 12, sum of lines 25 through 30 plus Medicare inpatient ancillary capital costs from Worksheet D Part II, column 6, line 101 plus column 8 line 101.

2) Identify total Medicare inpatient capital charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS capital CCR by dividing the amount in step 1 by the amount in step 2.

B. - Use of Alternative Data in Determining CCRs For Hospitals

Effective August 8, 2003, the CMS Central Office may direct Medicare contractors to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not

result in the most accurate CCR, then the Medicare contractor shall notify the CMS Regional Office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs and/or charges. The CMS Regional Office, in conjunction with the CMS Central Office, must approve the Medicare contractor's request before the Medicare contractor may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all IPPS claims processed after the update. Medicare contractors shall send notification to the Central Office via email *at* outliersIPPS@cms.hhs.gov.

C. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS

The Medicare contractor shall continue to update a hospital's operating and capital CCRs (in the Provider Specific File) each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCRs.

Subject to the approval of CMS, a hospital's operating and/or capital CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all hospital claims processed after the update.

D. - Request for use of a Different CCR by CMS, the Medicare Contractor or the Hospital

Effective August 8, 2003, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a hospital will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the hospital, the Medicare contractor notifies the CMS regional office and CMS Central Office of any such request. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request by the hospital or Medicare contractor for use of a different CCR. Medicare contractors shall send requests to the CMS Central Office *via email at outliersIPPS@cms.hhs.gov*.

E. - Notification to Hospitals Under the IPPS of a Change in the CCR

The Medicare contractor shall notify a hospital whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to a hospital about a change to their CCR(s).

F. - Hospital Mergers, Conversions, and Errors with CCRs

Effective November 7, 2005, for hospitals that merge, Medicare contractors shall continue to use the operating and capital CCRs calculated from the Medicare cost report associated with the surviving provider number. If a new provider number is issued, as explained in §20.1.2.2 below, Medicare contractors may use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR 412.84 (i)(3)(i), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). For non-IPPS hospitals (e.g., long term care, psychiatric, or rehabilitation hospitals) that convert to IPPS status, or IPPS hospitals that maintain their IPPS status but receive a new IPPS provider number the Statewide average CCR may be applied to that hospital. However, as noted in part C above, the Medicare contractor or the hospital may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report before it converted to IPPS status, or received a new provider number. The Medicare contractor must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS Central and Regional Offices.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek further guidance. Medicare contractors may contact the CMS Central Office via *email at outliersIPPS@cms.hhs.gov.*

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Medicare contractors should contact the CMS Regional and Central Office for further instructions. Medicare contractors may contact the CMS Central Office via *email at outliersIPPS@cms.hhs.gov*.

G. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio -27 -SSI Ratio -28 -Medicaid Ratio -47 -Capital Cost to Charge Ratio 49 -Capital IME and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the operating or capital CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

20.1.2.5 - Reconciliation

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

A. - General

Under 42 CFR §412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. This new regulation was implemented in two phases (further explanation on these two phases is provided below). Hospitals that Medicare contractors identified using the criteria in §I.A. of PM A-03-058 (under which Medicare contractors identified hospitals whose charges appeared to have been increasing at an excessive rate) are subject to the reconciliation policies described in this section for discharges occurring on or after August 8, 2003. For all other hospitals, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Subject to the approval of the CMS Central Office, a hospital's outlier claims will be reconciled at the time of cost report final settlement if they meet the following criteria:

1. The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2. Total outlier payments in that cost reporting period exceed $500,000.

To determine if a hospital meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §20.1.2.7. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

The first criterion requires a 10 percentage point fluctuation in the operating CCR only (and not the capital CCR). However, if a hospital meets both criteria, claims will be reconciled using the operating and capital CCRs from the final settled cost report.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent *via email* to *outliersIPPS@cms.hhs.gov*.

Even if a hospital does not meet the criteria for reconciliation, subject to approval of the Regional and Central Office, the Medicare contractor has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the Central Office via *email at outliersIPPS@cms.hhs.gov*. Upon approval of the CMS Regional and Central Office that a hospital's outlier claims need to be reconciled, Medicare contractors should follow the instructions in §20.1.2.7.

B. - Reconciling Outlier Payments for those Hospitals Identified in PM A-03-058

As stated above, for a hospital that met the criteria in §I.A. of PM A-03-058, reconciliation begins for discharges occurring on or after August 8, 2003. To establish whether a hospital's outlier payments are subject to reprocessing, Medicare contractors determine if the CCR and total outlier payments from the entire cost reporting period meet the two criteria in part A of this section. However, if both criteria for reconciliation are met, only the discharges that occurred between August 8, 2003 and the end of the cost reporting period will be reconciled. These hospitals will be subject to reconciliation in subsequent cost reporting periods if they meet the two criteria outlined in part A of this section. See example A below.

The Medicare contractors shall notify the CMS Regional Office and CMS Central Office of any hospital that meets the criteria for reconciliation. Notification to the CMS Central Office shall be sent *via email* to *outliersIPPS@cms.hhs.gov*. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§20.1.2.6 and 20.1.2.7.

EXAMPLE A:

Cost Reporting Period: 09/01/2002-08/31/2003

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively or final settled 2002 cost report)
Final settled operating CCR from 09/01/2002-08/31/2003 cost report: 0.50

Total outlier payout in 09/01/2002-08/31/2003 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the provider's claims for discharges from August 8, 2003 through August 31, 2003 shall be reconciled using the correct CCR of 0.50. The same criteria shall be applied to the cost report beginning on 09/01/2003 to determine whether reconciliation of outlier payments for that cost reporting period is necessary. For details on how to apply multiple CCRs in a cost reporting period, see example C below.

C. - Reconciling Outlier Payments for those Hospitals Not Identified in PM A-03-058

Beginning with the first cost reporting period starting on or after October 1, 2003, all hospitals are subject to the reconciliation policies set forth in this section. If a hospital meets the criteria in part A of this section, the Medicare contractor shall notify the CMS Regional Office and Central Office *via email* at *outliersIPPS@cms.hhs.gov*. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§20.1.2.6 and 20.1.2.7.

The following examples demonstrate how to apply the criteria for reconciliation:

EXAMPLE B:

Cost Reporting Period: 01/01/2004-12/31/2004

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the Medicare contractor shall notify the CMS Regional Office and Central Office. The provider's outlier payments for this cost reporting period will be reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. (See Example C below for instructions on how to weight the CCRs). The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE C:

Cost Reporting Period: 01/01/2004-12/31/2004
Operating CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2004-03/31/2004 (This CCR could be from the tentatively settled 2001 cost report)
- 0.50 from 04/01/2004-12/31/2004 (This CCR could be from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.35
Total Outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000
Weighted Average CCR: 0.474

CCR	Days	Weight	Weighted CCR
0.40	91	0.248 (91 Days / 366 Days)	(a) 0.099= (0.40 * 0.248)
0.50	275	0.751 (275 Days / 366 Days)	(b) 0.375= (0.50 * 0.751)
TOTAL	***366**		**(a)+(b) =0.4742**

***NOTE**: There are 366 days in the year because 2004 was a leap year.

The hospital meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed from 0.474 to 0.35 (which is greater than 10 percentage points) at the time of final settlement, and the provider received an outlier payment greater than $500,000 for the entire cost reporting period.

20.1.2.6 - Time Value of Money

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under §20.1.2.5, outlier payment may be adjusted to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the hospital's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If a hospital's outlier payments have met the criteria for reconciliation, CMS will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of that adjustment. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.

The following formula will be used to calculate the rate of the time value of money.

(Rate from Web site as of the midpoint of the cost report being settled / 365) * # of days from that midpoint until date of reconciliation. **NOTE**: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification *via* email from the Medicare contractor.

The following is an example of the computation of the adjustment to account for the time value of money:

EXAMPLE

Cost Reporting Period: 01/01/2004-12/31/2004
Midpoint of Cost Reporting Period: 07/01/2004
Date of Reconciliation: 12/31/2005

Number of days from Midpoint until date of Reconciliation: 549

Rate from Social Security Web site: 4.625%

Operating CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2002 or 2003 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR fluctuated from .40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has total outlier payments greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the CMS Regional and Central Office.

The Medicare contractor reprocesses and reconciles the claims. The reprocessing indicates the revised outlier payments are $700,000.

Using the values above, determine the rate that will be used for the time value of money: (4.625 / 365) * 549 = 6.9565%

Based on the claims reconciled, the provider is owed $100,000 ($700,000-$600,000) for the reconciled amount and $6,956.50 ($100,000 * 6.9565 %) for the time value of money.

20.1.2.7 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via *email to outliersIPPS@cms.hhs.gov* and regional office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted average operating CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled operating and capital CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office via email *at outliersIPPS@cms.hhs.gov* that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider records in the Inpatient Provider Specific File (IPSF) by entering the final settled operating and capital CCR from the cost report in the operating and capital CCR fields. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the revised operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the revised capital CCR in PSF field 47 -Capital Cost to Charge Ratio. No other elements in the IPSF (such as elements related to the DSH and IME adjustments) shall be updated for the applicable provider records in the IPSF that span the cost reporting period being reconciled aside from the elements for the operating and capital CCRs.

   ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

   - Type of Bill (TOB) equals 11X
   - Previous claim is in a paid status (P location) within FISS
   - Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the applicable IPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the IPPS, the Lump Sum Utility will calculate the difference between the original and revised operating and capital outlier amounts. If the difference between the original and revised operating and capital outlier amounts (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised operating and capital amounts (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The difference between the original and revised operating outlier amounts and the difference between the original and revised capital outlier amounts are two distinct amounts calculated by the lump sum utility and are recorded on two separate lines on the cost report.

11) The operating and capital time value of money amounts are two distinct calculations that are recorded separately on the cost report. Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §20.1.2.6. If the difference between the original and revised operating and capital outlier amounts is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised operating and capital outlier amounts is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original and revised operating and capital outlier amounts.

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 50-56, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 50-53 and 55 thru 56 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 24.99 of Worksheet E, Part A. For complete instructions on how to fill out these lines please see § 3630.1 of the Provider Reimbursement Manual, Part II. **NOTE**: Both the operating and capital amounts are combined and recorded on line 24.99 of Worksheet E, Part A.

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amounts (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 90-96, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 90-93 and 95 thru 96 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 69 of Worksheet E, Part A. **NOTE**: Both the operating and capital amounts are combined and recorded on line 69 of Worksheet E, Part A.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the operating and capital CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the IPSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the CMS Central Office via the address and email address provided in §20.1.2.1 (B).

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Revised Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Difference between these amounts
Original Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Revised Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)
Revised Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)
Difference between these amounts
Original Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Revised Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)

List of Data Elements for FISS Extract
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
TOT CHRG – total billed charges (claim page 3)
COV CHRG – total covered charges (claim page 3)
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
Original UNCOMP CARE AMT (claim page 40)
Revised UNCOMP CARE AMT (claim page 40)
Difference between these amounts
Original VAL PURC ADJ AMT (claim page 40)
Revised VAL PURC ADJ AMT (claim page 40)
Difference between these amounts
Original READMIS ADJ AMT (claim page 40)
Revised READMIS ADJ AMT (claim page 40)
Difference between these amounts
Original HAC PAYMENT AMT (claim page 40)

List of Data Elements for FISS Extract
Revised HAC PAYMENT AMT (claim page 40)
Difference between these amounts
Original EHR PAY ADJ AMT (claim page 40)
Revised EHR PAY ADJ AMT (claim page 40)
Difference between these amounts
Original PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Revised PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

150.24 - Determining the Cost-to-Charge Ratio

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

For all LTCHs, effective October 1, 2003, Medicare contractors are to use a CCR from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a LTCH's CCR.

A. - Calculating an overall LTCH Medicare Cost-to-Charge Ratio

For the LTCH PPS outlier calculations (short stay and high cost), Medicare's portion of hospital costs are determined by using a hospital's overall Medicare cost-to-charge ratio (CCR). At the end of the cost reporting period, the hospital prepares and submits a cost report to its Medicare contractor, which includes Medicare allowable costs and charges. The Medicare contractor completes a preliminary review of the as-submitted cost report and issues a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and a Notice of Program Reimbursement (NPR) is issued.

The Medicare contractor shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period).

Under the LTCH PPS, the following methodology shall be used to calculate a hospital's overall Medicare cost-to-charge ratio:

1) Identify total Medicare inpatient costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101)

2) Identify total Medicare inpatient charges obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data).

3) Determine the LTCH's overall Medicare CCR by dividing the amount in step 1 by the amount in step 2.

B. - Use of Alternative Data in Determining CCRs For LTCHs

Effective August 8, 2003, the CMS Central Office may direct Medicare contractors to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall notify the CMS Regional Office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, a CCR may be

revised more often if a change in a LTCHs operations occurs which materially affects a LTCH's costs and/or charges. The CMS Regional Office, in conjunction with the CMS Central Office, must approve the Medicare contractor's request before the Medicare contractor may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all LTCH claims processed after the update. Medicare contractors shall send notification to the CMS Central Office via *email to* outliersIPPS@cms.gov.

C. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the LTCH PPS

Medicare contractors shall continue to update a LTCH's CCR (in the Provider Specific File) each time a more recent cost report is settled (either final or tentative). A revised CCR shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

D. - Request for use of a Different CCR by CMS, the Medicare Contractor or the LTCH

Effective August 8, 2003, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a LTCH will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The LTCH is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the LTCH, the Medicare contractor notifies the CMS Regional Office and CMS Central Office of any such request. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request by the LTCH or Medicare contractor for use of a different CCR. Medicare contractors shall send requests *via email* to the CMS Central at *outliersIPPS@cms.hhs.gov*.

E. - Notification to Hospitals Under the LTCH PPS of a Change in the CCR

The Medicare contractor shall notify a LTCH whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to a LTCH about a change to their CCR.

F. - Mergers, Conversions and Errors with CCRs

Effective April 1, 2011, for LTCHs that merge, Medicare contractors shall continue to use the CCR from the LTCH with the surviving provider number. If a new provider number is issued, as explained in §150.25 below, Medicare contractors should use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR §§ 412.525(a)(4)(iv)(C)(1) and 412.529(c)(3)(iv)(C)(1), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). However, the policy of §150.24 part B and C can be applied to determine an alternative to the Statewide average CCR.

For newly classified LTCHs, that is those hospitals (e.g., short term acute, psychiatric, or rehabilitation hospitals) that meet the requirements set forth in 42 CFR 412.23(e), or LTCHs that receive a new LTCH provider number, the Statewide average CCR should be used until a CCR can be computed from the LTCH's cost report data, as described in part A of this section. However, as noted in part C above, the Medicare contractor or the LTCH may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report immediately preceding its classification as a LTCH or receiving a new LTCH provider number. The Medicare contractor must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS Central and Regional Offices. **NOTE: A newly classified LTCH must request an alternative CCR and receive approval from the CMS Central Office prior to the effective date of the hospital's classification as a LTCH in order for that alternative CCR to be effective beginning on the date of classification (as a LTCH). If the request and approval for an alternative CCR occurs after the effective date of the LTCH classification, then**

the use of the alternative CCR will be effective prospectively beginning with the date of the approval of the alternative CCR request.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek further guidance. Medicare contractors may contact the CMS Central Office via *email at outliersIPPS@cms.hhs.gov*.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Medicare contractors shall contact the CMS regional and Central Office for further instructions. Medicare contractors may contact the CMS Central Office via *email at outliersIPPS@cms.hhs.gov*.

G. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: 21 -Case Mix Adjusted Cost Per Discharge, 23 -Intern to Bed Ratio, 24 -Bed Size, 25 -Operating Cost to Charge Ratio, 27 -SSI Ratio and 28 -Medicaid Ratio. A separate history outside of the PSF is not necessary. (**NOTE**: PSF elements 23, 24, 27, 28 and 49 are only required for LTCHs effective 7/11/06.). The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

150.26 - Reconciliation

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

A. - General

For all LTCHs, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Subject to the approval of the CMS Central Office, Medicare contractors shall reconcile a LTCHs outlier claims at the time of cost report final settlement if they meet the following criteria:

1. The actual CCR is found to be plus or minus 10 percentage points from the CCR used during that cost reporting period to make outlier payments, and

2. *Applicable* outlier payments exceed $500,000 in that cost reporting period.

For the purposes of determining whether outlier payments meet the $500,000 threshold, MACs shall combine the following applicable payments depending on the cost reporting period:

- *a. For cost reporting periods beginning before October 1, 2015, high cost outlier payments made under 42 CFR §412.525 and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SHORT STAY OUTLIER PAYMENTS" on PS&R Report 11S);*
- *b. For cost reporting periods beginning on or after October 1, 2015 and ending before October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)), and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SSO STANDARD PAYMENTS" on PS&R Report 11S);*
- *c. For cost reporting periods beginning on or after October 1, 2015 and ending after October 1, 2017*
  - *i. For discharges before October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate*

discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)), and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SSO STANDARD PAYMENTS on PS&R Report 11S);

ii. *For discharges after October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)) ("OUTLIER" on PS&R Report 11S); or*

d. *For cost reporting periods beginning on or after October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)) ("OUTLIER" on PS&R Report 11S).*

To determine if a LTCH meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §150.28. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete. The criteria above replaces the criteria published in §III of PM A-03-058.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent *via email* to *outliersIPPS@cms.hhs.gov*.

Even if a LTCH does not meet the criteria for reconciliation, subject to approval of the CMS Regional and Central Office, the Medicare contractor has the discretion to request that a LTCH's outlier payments in a cost reporting period be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the CMS Central Office via *email to outliersIPPS@cms.hhs.gov*. Upon approval of the CMS regional and Central Office that a LTCH's high cost and short stay outlier claims need to be reconciled, Medicare contractors shall follow the instructions in §§150.27 and 150.28.

B. Reconciling Outlier Payments

Beginning with the first cost reporting period starting on or after October 1, 2003, all LTCHs are subject to the reconciliation policies set forth in this section. If a LTCH meets the criteria in part A of this section, the Medicare contractor shall follow the instructions below in §150.28. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§150.27 and 150.28. The following examples demonstrate how to apply the criteria for reconciliation:

Example A

Cost Reporting Period: 01/01/2004-12/31/2004

CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively settled 2002 cost report).

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.50.

Total outlier payments (short-stay and high cost outliers combined) in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 (by more than 10 percentage points) at the time of final settlement, and the provider received greater than $500,000 in (short-stay and high cost) outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the Medicare contractor notifies the CMS Regional Office and CMS Central Office. The provider's outlier payments for this cost reporting period will be reconciled using the actual CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, Medicare contractor shall calculate a weighted average of the CCRs in that cost reporting period. (See Example B below for instructions on how to weight the CCRs). The Medicare contractor shall then compare the weighted average CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total (combined short- stay and high cost) outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

Example B

Cost Reporting Period: 01/01/2004-12/31/2004

CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2004-03/31/2004 (This CCR is from the tentatively settled 2001 cost report)
- 0.50 from 04/01/2004-12/31/2004 (This CCR is from the tentatively settled 2002 cost report)

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.35

Total (short-stay and high cost) outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Weighted Average CCR: 0.474, completed as follows:

CCR	Days	Weight	Weighted CCR
0.40	91	0.248 (91 Days / 366 Days)	(a) 0.099= (0.40 * 0.248)
0.50	275	0.751 (275 Days / 366 Days)	(b) 0.375= (0.50 * 0.751)
TOTAL	***366**		**(a)+(b) =0.4742**

***NOTE**: There are 366 days in the year because 2004 was a leap year.

The LTCH meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed (by more than ten percentage points) from 0.474 to 0.35 at the time of final settlement, and the provider received (combined) outlier payments greater than $500,000 for the entire cost reporting period.

150.28 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a LTCH is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via *email to outliersIPPS@cms.hhs.gov* and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider

name, cost reporting begin date, cost reporting end date, total short stay and high cost outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office via email *at outliersIPPS@cms.hhs.gov* that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   *__NOTE__: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

7) Type of Bill (TOB) equals 11X
8) Previous claim is in a paid status (P location) within FISS
9) Cancel date is 'blank'

10) The Medicare contractor reconciles the claims through the applicable LTCH Pricer software and not through any editing or grouping software.

11) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

12) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

13) For hospitals paid under the LTCH PPS, the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility will reflect the difference between the total original short-stay and high cost outlier payment amount and the revised short-stay and high cost outlier payment amount. If the difference between the original and revised PPS Payment Amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised PPS Payment is negative, then a debit amount (deduction) shall be issued to the provider.

14) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §150.27. If the difference between the Original PPS Payment Amount

and Revised PPS Payment Amount from the Lump Sum Utility is a negative amount then the time value of money is also a negative amount. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original PPS Payment Amount and Revised PPS Payment Amount.

15) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original PPS amount by summing lines 1.02 and 1.05 from Worksheet E-3, Part I, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part I of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part I. For complete instructions on how to fill out these lines please see §3633.1 of the Provider Reimbursement Manual, Part II.

16) For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original PPS amount from Worksheet E-3, Part IV line 3, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part IV of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 20 of Worksheet E-3, Part IV.

17) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

18) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the LTCH PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 -Operating Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the Central Office, *via email at outliersIPPS@cms.hhs.gov.*

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)

List of Data Elements for FISS Extract
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG

List of Data Elements for FISS Extract
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

Addendum A - Provider Specific File

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></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>
</table>

Data Element	File Position	Format	Title	Description
3	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a “Y” or “N.” Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
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

Data Element	File Position	Format	Title	Description
				06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). Eff. 10/1/12, this provider type no longer valid. 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 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

Data Element	File Position	Format	Title	Description
				49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 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.

Data Element	File Position	Format	Title	Description
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.
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.

Data Element	File Position	Format	Title	Description
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
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. **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 — 40 — 60 3 — 60 — 40 4 — 80 — 20 5 — 100 — 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.

Data Element	File Position	Format	Title	Description
				Federal % / Facility% 1 25 75 2 50 50 3 75 25 4 100 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 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

Data Element	File Position	Format	Title	Description
				the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for

Data Element	File Position	Format	Title	Description
				each HHA. If no factor is provided, enter 1.00000.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a “1” or “2.”

Data Element	File Position	Format	Title	Description
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: 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

Data Element	File Position	Format	Title	Description
				• 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 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.

Data Element	File Position	Format	Title	Description
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.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor. *If Data Element 53 = "0", leave blank.*
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a 'Y' if the hospital is subject to a reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	269-310	X(42)	Filler	

250.5 - Medicare Payment for Ambulance Services Furnished by Certain CAHs

(Rev. 4390, Issued: 10-07-19, Effective: 10-01-19, Implementation: 10-07-19)

Medically necessary ambulance services furnished for dates of service on or after December 21, 2000 and prior to January 1, 2004, by a CAH or by an entity that is owned and operated by the CAH are paid based on 100 percent of the reasonable costs if the 35 mile rule for reasonable cost-based payment is met.

For dates of service on or after January 1, 2004, medically necessary ambulance services furnished by a CAH or by an entity that is owned and operated by the CAH are paid based on 101 percent of the reasonable costs if the 35 mile rule for reasonable cost-based payment is met.

For dates of service on or after December 21, 2000 and prior to October 1, 2011, in order for the 35 mile rule to be met, the CAH or the entity that is owned and operated by the CAH, must be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH or the entity.

For dates of service on or after October 1, 2011 *and prior to October 1, 2019*, in order for the 35 mile rule to be met, the CAH or the entity that is owned and operated by the CAH, must be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH. Additionally, if there is no provider or supplier of ambulance services located within a 35 mile drive of the CAH but there is an entity owned and operated by the CAH located more than a 35 mile drive from the CAH, that CAH-owned and operated entity can only be paid 101 percent of reasonable costs for its ambulance services if it is the closest provider or supplier of ambulance services to the CAH.

For dates of service on or after October 1, 2019, in order for the 35 mile rule to be met, the CAH or the entity that is owned and operated by the CAH, must be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH, excluding ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals either to or from the CAH. Additionally, if there is no provider or supplier of ambulance services located within a 35 mile drive of the CAH but there is an entity owned and operated by the CAH located more than a 35 mile drive from the CAH, that CAH-owned and operated entity can only be paid 101 percent of reasonable costs for its ambulance services if it is the closest provider or supplier of ambulance services to the CAH.

Section 205 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 exempts certain CAHs from the current Medicare ambulance cost per trip payment limit as well as from the ambulance fee schedule. Section 205(a) of BIPA states:

> The Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished (A) by a CAH (as defined in §1861(mm)(1)), or (B) by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

Those CAHs and CAH-owned and operated entities that meet the 35 mile rule for reasonable cost-based payment shall report condition code B2 (CAH ambulance attestation) on their bills.

When the 35 mile rule for reasonable cost-based payment is not met, the CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the CAH, is paid based on the ambulance fee schedule.