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

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PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

CR 11361 provides the Fiscal Year (FY) 2020 update to the Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS). Please make sure your billing staffs are aware of these updates.

BACKGROUND

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a PPS for Medicare payment of inpatient hospital services. 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) also 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 PPSs annually. CR 11361 provides those changes for FY 2020.

The following policy changes for FY 2020 were displayed in the Federal Register on August 2, 2019, with a publication date of August 16, 2019, and the corresponding correction document published on October 8, 2019 in the Federal Register. All items covered in this CR are effective for hospital discharges occurring on or after October 1, 2019, through September 30, 2020, unless otherwise noted.

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New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2019, and 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 must be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

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

- FY 2020 Final Rule Tables web page: 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 web page: 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 web page: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-MAC.html

Note: The files on the web pages listed above are also available 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 that reads, “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 web page. 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 web page.

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 based on 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. MACs 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.

The two FY 2020 new MS-DRGs are:

- MS-DRG 319 Other Endovascular Cardiac Valve Procedures with MCC
- MS-DRG 320 Other Endovascular Cardiac Valve Procedures without MCC

The two FY 2020 deleted MS-DRGs are:

- MS-DRG 691 Urinary Stones with ESW Lithotripsy with CC/MCC
- MS-DRG 692 Urinary Stones with ESW Lithotripsy without CC/MCC

Also, CMS revised the following MS-DRG title descriptions for FY 2020:

- 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

CMS reduces a hospital's IPPS payment 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 with FY 2020, the new technology add-on payment percentage under 42 CFR 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 codes 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 NCD of 70842012001 or 65293000901 (VABOMERE™ Meropenem-Vaborbactam Vial)
    - FDA designated the technology as QIDP
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
    - FDA designated the technology as QIDP
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. COLA Update for IPPS PPS

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

G. Updating the MACs Provider Specific File (PSF) for Wage Index, Reclassifications and Redesignations and Wage Index Changes and Issues

For FY 2020, CMS made the following changes to the wage index:

- 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,
- Applied 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.

H. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act and Certain Urban Hospitals Reclassified as Rural Hospitals Under 42 CFR 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 for 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 outmigration adjustment has effective 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 is on the FY 2020 MAC Implementation File webpage.

On the FY 2020 MAC Implementation File web page, you will find:

- The list of hospitals that have waived Lugar status for FY 2020
- Complete details on how to fill out the PSF for these hospitals

An urban hospital that reclassifies as a rural hospital under 42 CFR 412.103 is considered rural for all IPPS purposes.

Note: Hospitals reclassified under 42 CFR 412.103 are not eligible for the capital Disproportionate Share Hospitals (DSH) adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1).

I. Multicampus Hospitals

1. Wage Index

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the Core-Based Statistical Area (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, MACs add a suffix to the CMS Certification Number (CCN) of the hospital in their 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.

Generally, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

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 42 CFR 412.103.

Note: MLN Matters article MM10869 is available for review at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10869.pdf.

Specifically, the main campus of a hospital cannot obtain an 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)) is 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 42 CFR 412.92 for SCH; 42 CFR 412.96 for RRC; 42 CFR 412.103 for rural reclassification; and 42 CFR 412.108 for MDH require data, such as bed count, number of discharges, or case-mix index (as examples).

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

As explained in CR 10869, 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 42 CFR 412.108(b)(4) and 42 CFR 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 FY 2020

Section 50204 of the BBA modified the definition of a low-volume hospital, as well as 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 2019-2022, 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 FY.

Section 50204 also amended the statute to provide that, for discharges occurring in FYs 2019-2022, the Secretary of the Department of Health and Human Services (HHS) will 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 FY. A hospital's total discharges, including Medicare and non-Medicare discharges, are based on the hospital's most recently submitted cost report. The regulations implementing the hospital payment adjustment policy are in 42 CFR 412.101.

For FY 2020, a hospital had to make a written request for low-volume hospital status that was 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 and mileage criteria applicable for FY 2020.

As in previous years, such a hospital had to send written verification received by its MAC no later than September 1, 2019, stating that it meets the mileage criteria applicable for CY 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 as of the time of the MAC's low-volume hospital status determination, as follows:

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

Note: "Number of total discharges" includes Medicare and non-Medicare discharges and is based on the hospital's most recently submitted cost report at the time of the hospital's low-volume hospital payment adjustment request.

L. Hospital Qualify Initiative

Hospitals that receive the quality initiative bonus are listed at 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/.

Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2020 under the Hospital IQR Program is in MAC Implementation File 3 on the FY 2020 MAC Implementation Files web page.

For new hospitals, MACs will 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 (PRS) 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 FY to inform them of the Hospital IQR Program reporting requirements.

M. Hospital-Acquired Condition Reduction Program (HAC)

The HAC Reduction Program requires the Secretary 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 (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 FY.

CMS did not make public the list of providers subject to the HAC Reduction Program for FY 2020 in the final rule because hospitals have until August 2019 to notify us of any errors in the calculation of their Total HAC Score under the Scoring Calculation Review and Corrections period. Updated hospital-level data for the HAC Reduction Program will be made public on the Hospital Compare website in January 2020.

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).

O. Hospital Readmission 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). 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.

P. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, hospitals receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of the aggregate amount available for uncompensated care payments based on its share of total uncompensated care reported by Medicare DSH hospitals.

The Medicare DSH payment is reduced to 25 percent of the amount they previously would have received under the current statutory formula in Pricer. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment is

applied in Pricer.

In the FY 2020 IPPS/LTCH PPS Final Rule, CMS 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 on the FY 2020 Final Rule Data Files webpage.

The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per-discharge basis.

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 is 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.

Note: It is possible that there are additional new hospitals during FY 2020 and therefore those would not be listed on the Medicare DSH Supplemental Date File.

Hospitals that have a merger during FY 2020 will have their pro rata Factor 3 reconciled at cost report settlement by the MAC. The Factor 3 is calculated based on annualizing both the provider's uncompensated care data (line 30) and combining with the respective surviving CCN.

Q. Outlier Payments

1. 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:

- 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).

- 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
- 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 the 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.

2. 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 (SSOs) 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 42 CFR 412.529 to specify that SSO payments will be reconciled only for discharges occurring before October 1, 2017.

Accordingly, CR 11361 is facilitating corresponding manual revisions to the Medicare Claims Processing Manual, Chapter 3, Section 150.26 to reflect the FY 2019 rule changes to LTCH short stay outlier payment policies.

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, CMS means Medicare-participating providers that submit claims under Medicare for ambulance services (for example, hospitals, CAHs, skilled nursing facilities, and home health agencies). By “supplier” of ambulance services, CMS means an entity that provides ambulance services and is independent of any Medicare-participating or non-Medicare-participating provider.

It was brought to CMS’ 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.

CMS 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, CR 1361 makes corresponding manual revisions to the Medicare Claims Processing Manual, Chapter 4, Section 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 in the FY 2020 Final Rule Tables web page (Table 1E). Other FY 2020 LTCH PPS Factors are available in MAC Implementation File 2 on the FY 2020 MAC Implementation file web page.

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 via the site-neutral payment rate. The application of the site-neutral payment rate is codified in the regulations at 42 CFR 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 in FYs 2018 and 2019. The blended payment rate is comprised of 50 percent of the site-neutral payment rate for the discharge and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge.

This transitional blended payment rate for site-neutral rate LTCH discharges is included in the

Pricer logic.

Under Section 51005 of the Bipartisan Budget Act of 2018, 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 the cost-reporting periods in FY 2016, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCH's Fee-For-Service (FFS) discharges, which received LTCH PPS standard Federal rate payment to the LTCH's total number of LTCH PPS discharges. MACs must continue to provide notification to the LTCH of its DPP upon final settlement of the cost report.

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 this fact. 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.

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 an LTCH does not submit quality-reporting data in accordance with the LTCHQR Program for that year.

E. Provider-Specific File (PSF)

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 web page. Per the regulations in 42 CFR 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 489.18).
2. LTCHs with a total CCR in excess of 1.280 (referred to as the total CCR ceiling).
3. Any hospital for which data to calculate CCR is not available.

Note: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in Chapter 3, Section 150.24 of the Medicare Claims Processing Manual.

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, are found in the FY 2020 IPPS/LTCH PPS final rule and also located in MAC Implementation File 2 available on the FY 2020 MAC Implementation Files web page.

Note: The same COLA factors are used under the IPPS and the LTCH PPS for FY 2020.

G. 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 42 CFR 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2020 IPS/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.

ADDITIONAL INFORMATION

The official instruction, CR 11361, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4390CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
October 8, 2019	Initial article released.

license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816. You may also contact us at ub04@healthforum.com

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