CMS Manual System

Pub. 100-19 Demonstrations

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 20 **Date: MARCH 4, 2005**

CHANGE REQUEST 3707

SUBJECT: **Full Replacement of CR 3220, Method of Reimbursement for Inpatient Services for Rural Hospitals Participating Under Demonstration Authorized by Section 410A of the Medicare Modernization Act. CR 3220 is rescinded.**

I. SUMMARY OF CHANGES: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) mandates a demonstration that establishes rural community hospitals. Thirteen hospitals will participate in the demonstration. An eligible hospital is located in a rural area, has fewer than 51 acute care beds, makes available 24-hour emergency services, and is not eligible for Critical Access Hospital designation. In the first cost reporting period on or after implementation of the demonstration, the hospital's payment for covered inpatient services will be the reasonable cost of providing such services. For subsequent cost reporting periods, payment is the lesser of reasonable cost or a target amount, which is defined as the first year's reasonable cost updated by the market basket percentage increase in the second year, and, for a later year, the target amount increased by the market basket percentage increase. This shall be a 5 year demonstration.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2004
IMPLEMENTATION DATE: March 18, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Funding for Medicare contractors is available through the regular budget process for costs required for implementation.

IV. ATTACHMENTS:

X	**Business Requirements**
	Manual Instruction
	Confidential Requirements

	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-19	Transmittal: 20	Date: March 4, 2005	Change Request 3707

SUBJECT: Full Replacement of CR 3220, Method of Reimbursement for Inpatient Services for Rural Hospitals Participating Under Demonstration Authorized by Section 410A of the Medicare Modernization Act. CR 3220 is rescinded.

This replacement of the method of reimbursement for inpatient services for rural hospitals participating under the demonstration authorized by section 410A of the Medicare Modernization Act changes the way interim payments are calculated and administered for the project. CMS will avoid the need to make any changes in FISS programming by maintaining payment for Medicare inpatient services on the basis of IPPS, and calculating an adjustment in interim payments on the basis of a level payment. These interim payments will be calculated on the basis of comparing what a cost-based settlement would be to the previous year's payment as determined by the cost report. CMS will issue further instructions on the settlement process for the first and future years of the demonstration.

I. GENERAL INFORMATION

A. Background: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates a demonstration that establishes rural community hospitals. Thirteen hospitals will participate in the demonstration. An eligible hospital is located in a rural area, has fewer than 51 acute care beds, makes available 24-hour emergency services, and is not eligible for Critical Access Hospital designation.

B. Policy: For chosen hospitals:

a) In the first cost reporting period on or after implementation, the hospital's payment for covered inpatient services, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital, will be the reasonable cost of providing such services.

b) In subsequent cost reporting periods of the demonstration program, payment for covered inpatient services is the lesser of the reasonable costs of providing such services or the target amount.

i) In the second cost reporting period of the demonstration, the target amount is the first year's reasonable cost increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act) in the market basket percentage increase for that particular cost reporting period.

ii) In the third through fifth cost reporting periods, the target amount is the previous year's target amount increased by the applicable percentage increase in the market basket percentage increase for that particular cost reporting period.

c) Each chosen hospital will be able to participate for 5 consecutive cost reporting periods. For participating hospitals, this payment change will begin with cost report periods beginning on or after October 1, 2004. There are four providers who have entered the demonstration to date. Each hospital's fiscal intermediary will need to establish an interim payment rate effective for those providers with fiscal years beginning on or after October 1, 2004. The remaining hospitals will begin according to their cost report start dates, which are dispersed through the Federal fiscal year.

d) For each cost reporting period, the fiscal intermediary shall collect necessary data from each hospital for the provider specific file in order to calculate disproportionate share percentages. The fiscal intermediary will not make any payment for Medicare disproportionate share in addition to the cost-based payment for inpatient services. The purpose of this data collection is that hospitals will use these percentages to potentially be eligible for non-Medicare benefit programs tied to the disproportionate share percentage or status.

e) Hospitals participating in the demonstration may be able to participate in other CMS demonstrations.

f) Hospitals will receive Medicare inpatient payment from their current fiscal intermediary. The following table lists the hospitals selected for the demonstration along with their fiscal intermediaries:

Provider No.	Hospital Name	City, State	Contractor Number	Contractor Name	Cost Report End Date
20024	Central Peninsula General Hospital	Soldotna, Alaska	430	Noridian	6/30
20008	Bartlett Regional Hospital	Juneau, Alaska	430	Noridian	6/30
270002	Holy Rosary Healthcare	Miles City, Montana	250	BCBS of Montana	5/31
270032	Northern Montana Hospital	Havre, Montana	250	BCBS of Montana	6/30
280117	Tri-County Area Hospital District	Lexington, Nebraska	260	BCBS of Nebraska	6/30
280054	Beatrice Community Hospital and Health Center	Beatrice, Nebraska	52280	Mutual of Omaha	9/30
280108	Phelps Memorial Health Center	Holdrege, Nebraska	260	BCBS of Nebraska	12/31
280021	Community Hospital	McCook, Nebraska	260	BCBS of Nebraska	6/30
280111	Columbus Community Hospital	Columbus, Nebraska	52280	Mutual of Omaha	4/30
290006	Banner Churchill Community Hospital	Fallon, Nevada	52280	Mutual of Omaha	12/31
320013	Holy Cross Hospital	Taos, New Mexico	400	Trailblazers	5/31
430048	Lookout Memorial Hospital	Spearfish, South Dakota	11	Cahaba	6/30
460033	Garfield Memorial Hospital	Panguitch, Utah	350	Medicare Northwest	12/31

Provider Education: None.

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II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3707.1	CMS has identified 13 hospitals eligible to participate in the demonstration.									CMS-ORDI Staff
3707.2	Effective for cost reports beginning on or after 10/01/04, for each participating hospital, payment for inpatient services and ONLY inpatient services of a demonstration hospital, i.e, a hospital identified in the table under B. f), shall be the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement.	X								
3707.2.1	Each year of the demonstration, for cost reports beginning 10/1/04 or after, the FI will continue to pay each hospital under the IPPS method on a claim-by-claim basis.	X								
3707.2.2	For each participating hospital, i.e., demonstration hospital identified in the table under B. f) effective for cost reports beginning on or after 10/01/04, the FI shall adjust interim payments for inpatient services to reflect the reasonable cost of providing these services	X								
3707.2.3	Using the latest finalized or tentatively settled cost report, whichever is from the later period, the FI shall determine what payments the hospital would have received under the PPS method and also under a reasonable cost method of reimbursement.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3707.2.4	The FI shall calculate the variance between the PPS and reasonable cost methods, and adjust the interim payments for the hospital. This adjustment should be made in the form of a bi-weekly level payment, based on a per discharge calculation as for PIP providers. The FI should target this adjustment to interim payments across the cost report period for each hospital so as to approximate the amount to be paid under cost-based reimbursement for the cost reporting period.	X								
3707.2.5	Participating hospitals, with certified swing-beds will also receive cost-based reimbursement for swing-bed services. The FI shall continue to pay swing-bed services under the SNF PPS method on a claim-by-claim basis. The FI shall calculate the variance between the SNF PPS and reasonable cost methods, making bi-weekly level payments as described above for the hospital inpatient services.	X								
3707.2.6	It will be optional for participating hospitals with swing-beds whether to fulfill the Minimum Data Set (MDS) requirements during their participation in the demonstration program									Hospital
3707.2.7	For hospitals with swing-beds that participate in the demonstration and comply with the MDS provisions that are customarily required of swing-bed hospitals, the FI will use the MDS information to calculate SNF PPS payment as usual for swing-bed hospitals.	X								Hospital
3707.2.8	For participating hospitals with swing-beds that choose not to fulfill customary MDS requirements, the FI will calculate SNF PPS payment according to standard rules applicable to such circumstances.	X								Hospital

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3707.3	For each cost reporting period, the FI will collect necessary data from each hospital for the provider-specific file in order to be able to report disproportionate share percentages.	X								Hospital
3707.4	For the purposes of payment under this demonstration, inpatient services shall be defined as those billed by the hospital with a type of bill code of "11X". Swing-bed services shall be defined as those billed with the type of bill code of "18".	X								Hospital
3707.5	The date of discharge shall determine into what cost reporting period a claim falls.	X								
3707.6	Claims that overlap cost reporting periods shall not be split. They shall be assigned to the cost reporting period for the date of discharge.	X								
3707.7	Hospitals shall be able to terminate participation prior to the official end of the demonstration, effective at the beginning of the cost report period.	X								Hospital

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2004 **Implementation Date:** March 18, 2005 **Pre-Implementation Contact(s):** Sid Mazumdar, x66673 **Post-Implementation Contact(s):**	**Funding for Medicare contractors is available through the regular budget process for costs required for implementation.**

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