

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash –

Revised products from the Medicare Learning Network® (MLN)

- [“Sole Community Hospital”](#), Fact Sheet, ICN 006399, downloadable

MLN Matters® Number: MM8076

Related Change Request (CR) #: CR 8076

Related CR Release Date: December 21, 2012

Effective Date: October 2, 2011

Related CR Transmittal #: R86DEMO

Implementation Date: January 22, 2013

Implementation of the Hospital Value-Based Purchasing Program and Hospital Readmission Reduction Program for the Rural Community Hospital Demonstration for FY 2013

Provider Types Affected

This MLN Matters® Article is intended for hospitals participating in the Rural Community Hospital Demonstration Program that submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A Medicare Administrative Contractors (A MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8076 which clarifies the methodology according to which payment enhancements (possible for the Hospital Value-Based Purchasing (HVBP) program) and payment reductions (possible for both the HVBP and Hospital Readmission Reduction Programs) will be calculated and implemented for Fiscal Year (FY) 2013. **This article is intended only for hospitals participating in the Rural Community Hospital Demonstration Program, and it applies to cost report periods beginning after October 1, 2011.**

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Make sure that your billing staffs are aware of these changes.

Background

Rural Community Hospital Demonstration Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 410A; see <http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf>) mandated that the Centers for Medicare & Medicaid Services (CMS) establish a Rural Community Hospital Demonstration Program demonstration that establishes rural community hospitals, which receive reimbursement for inpatient services according to a cost-based methodology.

To be eligible to participate in the Rural Community Hospital demonstration, a hospital needs to be:

- Located in a rural area;
- Have fewer than 51 acute care beds;
- Make available 24-hour emergency services; and
- Ineligible for Critical Access Hospital designation.

The Affordable Care Act (Sections 3123 and 10313; see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm>) both expanded and extended the Rural Community Hospital Demonstration Program for an additional 5-year period. Currently, there are 23 hospitals participating in the demonstration. Seven hospitals were selected between 2004 and 2008, while 16 are participating as result of the Affordable Care Act expansion. The period of performance will conclude December 31, 2016.

Both of the following programs apply to hospitals participating in the Rural Community Hospital demonstration:

- **The Hospital Value-Based Purchasing Program (HVBP)** - implemented by CMS as authorized by Section 3001(a) of the Affordable Care Act under which value-based incentive payments are made in a given fiscal year to hospitals meeting performance standards specified by CMS for the fiscal year. The value-based incentive payment will be applied to discharges beginning October 1, 2012; and
- **The Hospital Readmission Reduction Program** - established by Sections 3025 and 10309 of the Affordable Care Act, which is effective for discharges from an applicable hospital beginning October 1, 2012.

Both the HVBP and the Hospital Readmission Reduction Program will apply to the hospitals participating in the Rural Community Hospital demonstration. CR8076 clarifies the methodology according to which payment enhancements (possible for the HVBP) and payment reductions (possible for both the HVBP and Hospital Readmission Reduction Program) will be calculated and implemented beginning in FY 2013, for the hospitals participating in the demonstration, applying to their cost report periods that include discharges beginning October 1, 2012, i.e., cost report periods beginning after October 1, 2011.

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The methodology CMS will use to determine the hospital's payment for covered inpatient services (for each participating hospital's cost report year, and net of adjustments for the HVBP Program and the Hospital Readmission Reductions Program), is outlined in Change Request (CR) 7505 (as amended by CR 7898). CR7505 (Transmittal 77 dated July 22, 2011) can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R77DEMO.pdf> on the CMS website, and CR7898 (Transmittal 84 dated August 17, 2012) can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R84DEMO.pdf> on the CMS website. All provisions of CR7505 and CR7898 remain in effect.

CR8076 further clarifies (for hospitals participating in the Rural Community Hospital demonstration) the methodology CMS will use to calculate their:

- Payment enhancements (possible for the HVBP program), and
- Payment reductions (possible for both 1) the HVBP and 2) the Hospital Readmission Reduction Program).

Hospital Value-Based Purchasing Program (HVBP)

The HVBP applies to subsection (d) hospitals, with certain exceptions. Because they are subsection (d) hospitals, hospitals participating in the Rural Community Hospital demonstration will be included in the HVBP Program. CMS will determine exceptions for individual hospitals on the basis of rules specific to the HVBP program – there will be no exception on the basis of participation in the demonstration.

Total Performance Score

CMS will calculate a Total Performance Score (TPS) for each hospital eligible for the HVBP Program. The regulations that implement the provision for the TPS are in Subpart I of 42 CFR part 412 (412.160 through 412.162; see <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr;sid=389f40956b40a469c130f2f21af073e7;rgn=div2;view=text;node=20120831%3A1.8;idno=42;cc=ecfr;start=1;size=25> on the Internet).

Value Based Incentive Payment

Each eligible hospital's value-based incentive payment percentage will be based on its total performance score. In the FY 2013 IPPS/LTCH PPS final rule, CMS established:

- The methodology used to calculate the hospital value-based incentive payment adjustment factor,
- The review and corrections process, and
- The appeal process.

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This enables hospitals to review information used to calculate their Total Performance Scores and submit requests for corrections to the information before it is made public. You can find the FY 2013 IPPS/LTCH PPS final rule at <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html> on the CMS website.

Implementing the HVBP

CR8041 provides instructions for your Medicare Administrative Contractors (MACs) to implement the HVBP provision. You can review CR8041 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2539CP.pdf> on the CMS website.

According to CR8041, CMS will not implement the value-based incentive payment adjustments or base operating DRG amount reductions until January 2013.

For each hospital participating in the Rural Community Hospital demonstration that is eligible for the HVBP, your MAC will calculate either:

- The value-based incentive payment adjustment, or
- The base operating Diagnosis Related Group (DRG) amount reduction.

This would apply to the hospital for FY 2013 as if the hospital were paid under the IPPS.

Your MAC will 1) **add this amount to** (if it's a value-based incentive payment adjustment), or 2) **subtract this amount from** (if it is a reduction) the payment amount for inpatient services that the hospital would receive under the cost-based reimbursement methodology for the Rural Community Hospital demonstration.

For each hospital, the MAC will apply the adjustment (calculated on the basis of the HVBP methodology for FY 2013) to the reimbursement amount determined for the first cost reporting year beginning after October 1, 2012. This addition will occur at cost report settlement.

Hospital Readmission Reduction Program

This program requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR (412.150 through 412.154 as established in the FY 2013 IPPS/LTCH PPS final rule. (See <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=389f40956b40a469c130f2f21af073e7;rgn=div2;view=text;node=20120831%3A1.8;idno=42;cc=ecfr;start=1;size=25> on the Internet)

In the FY 2013 IPPS final rule CMS finalized that subsection (d) hospitals are subject to the Hospital Readmissions Reduction Program. See <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html> on the CMS website.

Hospitals participating in the Rural Community Hospital demonstration will be subject to the Hospital Readmissions Reduction Program.

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For FY 2013, the methodology to calculate excess readmissions ratios and readmissions payment adjustment factors is discussed in the FY 2013 IPPS final rule.

For hospitals participating in the Rural Community Hospital demonstration, the readmission adjustment factor is applied in accordance with CR8041, as if the hospital were paid under the IPPS. See CR8041 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2539CP.pdf> on the CMS website.

The readmission adjustment factor is applied to a hospital's base operating amount to determine the amount reduced from a hospital's inpatient payment due to excess readmissions.

For hospitals participating in the Rural Community Hospital demonstration, your MAC will calculate the amount of reduction for FY 2013, and apply it to the amount otherwise to be paid for inpatient services for the first cost reporting period beginning after October 1, 2012. This reduction will occur at cost report settlement.

Additional Information

The official instruction, CR8076 issued to your FIs and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R86DEMO.pdf> on the CMS website.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, and RHHIs at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

The CMS official source of information about the Hospital Value-based Purchasing (HVBP) Program can be reviewed at <http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html> on the CMS website.

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