

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



News Flash – The publication titled “Hospital Outpatient Prospective Payment System” (March 2011), is now available in print format from the Medicare Learning Network®. This fact sheet is designed to provide education on the Hospital Outpatient Prospective Payment System (OPPS) including background, ambulatory payment classifications, how payment rates are set, and payment rates under the OPPS. To place your order, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html> on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

MLN Matters® Number: MM7505 **Revised**

Related Change Request (CR) #: 7505

Related CR Release Date: July 22, 2011

Effective Date: January 1, 2010

Related CR Transmittal #: R77DEMO

Implementation Date: August 22, 2011

Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under Demonstration Authorized by Section 410A of the Medicare Modernization Act. Sections 3123 and 10313 of the Affordable Care Act authorized an expansion of the demonstration and an extension for an additional 5-year period. This Change Request (CR) gives instructions for this additional 5-year period. This CR is an extension of CR5020 for this additional 5-year period.

Note: This article was updated on August 8, 2012, to reflect current Web addresses. All other content remains the same.

Provider Types Affected

This article is for specific rural Inpatient Acute Care hospitals (see list of provider numbers below) that bill Medicare contractors (Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

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Provider Action Needed

If you are an affected hospital, make sure your billing and reimbursement staffs are aware of these changes.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated a demonstration that establishes rural community hospitals. 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. As of November 2010, out of 18 hospitals chosen between 2004 and 2008, 8 hospitals were still participating in the demonstration. Holy Cross Hospital in Taos, NM is withdrawing, effective with its cost report ending on May 31, 2011. Its participation in the continuation period will be effective for the cost report year June 1, 2010 – May 31, 2011.

Sections 3123 and 10313 of the Affordable Care Act both expanded and extended the demonstration. Hospitals continuing participation from the initial period are grandfathered into the project – with a 5-year continuation period for each hospital.

In addition, 18 new hospitals will begin the demonstration. Each will participate for a period of 5 years, beginning on its first cost report start date on or after April 1, 2011. The period of performance will conclude December 31, 2016.

Key Points

For each participating hospital:

1. In the first cost reporting period (the first cost reporting period starting in Calendar Year (CY) 2010 for continuing hospitals, the first cost reporting period on or after April 1, 2011, for newly participating hospitals), 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. Swing bed services are included among the covered services for which the hospital receives payment on the basis of reasonable costs.
2. Reimbursement for the reasonable cost of services to beneficiaries is made according to the principles stated in 42 CFR 413 and Chapter 21 of Part I of the "Provider Reimbursement Manual." As stated in these documents, only costs that can be directly attributed to patient care will be reimbursed.
3. One hundred percent of bad debt will be included in the determination of reasonable cost.
4. Capital costs will be included in the determination of reasonable cost.

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5. Costs of outpatient services performed within 72 hours prior to inpatient admission will be bundled, as appropriate, as part of the cost of the inpatient service.
6. The reasonable cost payment for the first cost reporting period applies to the first cost reporting period starting in CY 2010 for the 8 hospitals continuing from the initial demonstration period. It applies to the first cost reporting period on or after April 1, 2011, for the 18 newly participating hospitals.
7. In subsequent cost reporting periods of the demonstration program, payment for covered inpatient services is the lesser of reasonable costs of providing such services or the target amount. This methodology applies to all 26 participating hospitals.
8. The payment methodology for covered inpatient services during subsequent cost reporting periods, i.e., Years 2 through 5, is described in Attachment A of CR7505, which is viewable at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R77DEMO.pdf> on the Centers for Medicare & Medicaid services (CMS) website.
9. If a hospital offers swing bed services, the Medicare FI/MAC will calculate two separate target amounts for the purpose of calculating reimbursement:
 - o for acute care services; and
 - o for swing-bed services.
10. If a hospital provides only acute care services, then there will be only one target amount for acute care services.
11. Hospitals participating in the demonstration will be able to participate in other CMS demonstrations.
12. Hospitals participating in the demonstration will not be able to receive the low volume payment adjustment in addition.
13. The MAC or FI will not make any Medicare disproportionate share payment in addition to the cost-based payment for inpatient services. For each cost reporting period, the MAC or FI will collect necessary data from each hospital for the provider specific file in order to calculate disproportionate share percentages. 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.
14. Under the demonstration, a hospital will also not receive add-on payments as a Sole Community Hospital or Medicare Dependent Hospital.
15. If in either Fiscal Year (FY) 2011 or FY 2012 a participating hospital receives an additional payment for qualifying hospitals with lowest enrollee Medicare

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spending under section 1109 of the Affordable Care Act, the MAC or FI will subtract the amount paid under this provision from the cost-based payment for Medicare inpatient services calculated under this demonstration methodology. This deduction will be made only if the additional payment being made to the hospital under Section 1109 occurs at a point in time concurrent with the hospital's period of performance in the demonstration. For example: if payment under Section 1109 occurs in September 2011, and:

- A hospital is one of the originally participating hospitals, beginning the extension period with cost report period starting January 1, 2010, then the amount received under Section 1109 will be subtracted from the demonstration payment for the cost report year January 1, 2011 – December 31, 2011.
- A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year July 1, 2011 – June 30, 2012, then the amount received under Section 1109 will be subtracted from the demonstration payment for that cost report year.
- A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year January 1, 2012 – December 31, 2012, then the amount of the payment for FY 2011 will not be subtracted for the hospital.

16. Since hospitals participating in the demonstration are considered to be subsection (d) hospitals, they will be able to participate in the Medicare Health Information Technology (HIT) incentive payment program. They will be required to follow the regulations as subsection (d) hospitals.

The following hospitals are participating in the demonstration and they will also be receiving additional payments under Section 1109:

Originally Participating Hospitals –

- Columbus Community Hospital, Columbus, NE;
- Holy Cross Hospital, Taos, NM;
- Brookings Hospital, Brookings, SD; and
- Garfield Memorial Hospital, Panguitch, UT.

Newly Selected Hospitals –

- Yampa Valley Medical Center, Steamboat Springs, CO;
- St Anthony Regional Hospital, Carroll, IA;
- Skiff Medical Center, Newton, IA;

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- Lakes Regional Healthcare, Spirit Lake, IA;
- Grinnell Regional Medical Center, Grinnell, IA;
- Geary Community Hospital, Junction City, KS;
- Miles Memorial Hospital, Damariscotta, ME;
- Inland Hospital, Waterville, ME;
- San Miguel Hospital Corporation, Las Vegas, NM; and
- Cibola General Hospital, Grants, NM.

Additional Information

The official instruction, CR7505 issued to your FI or MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R77DEMO.pdf> on the CMS website.

If you have any questions, please contact your FI or MAC 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.

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