CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 131	**Date: December 4, 2015**
	Change Request 9165

Transmittal 123, dated October 9, 2015, is being rescinded and replaced by Transmittal 131 to change the effective and implementation date. All other information remains the same.

SUBJECT: Implementing Payment Changes for FCHIP (Frontier Community Health Integration Project), Mandated by Section 123 of MIPPA 2008 and as Amended by Section 3126 of the ACA of 2010 (This CR Rescinds and Replaces CR 8683)

I. SUMMARY OF CHANGES: Section 123 of the Medicare Improvements for Providers and Patients Act of 2008 authorizes a demonstration project on community health integration models in certain rural counties to develop and test new models for the delivery of healthcare in order to better integrate the delivery of acute care, extended care, and other healthcare, thereby improving access to care for Medicare and Medicaid beneficiaries located in very sparsely populated areas. The Centers for Medicare & Medicaid Services (CMS) will be modifying Medicare payment rules for specified Critical Access Hospitals (CAHs) and ambulance services in the following three States: Montana, Nevada, and North Dakota.

CMS will select the participating CAHs prior to July 1, 2016. CMS will identify for the Medicare Administrative Contractor (MAC) all providers that will be subject to the respective payment changes for ambulance services, long term care services, and cost based reimbursement for telehealth services.

EFFECTIVE DATE: July 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2016

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
N/A	N/A

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:
Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: Section 123 of the Medicare Improvements for Providers and Patients Act of 2008 authorizes a demonstration project on community health integration models in certain rural counties to develop and test new models for the delivery of healthcare in order to better integrate the delivery of acute care, extended care, and other healthcare, thereby improving access to care for Medicare and Medicaid beneficiaries located in very sparsely populated areas. The Centers for Medicare and Medicaid Services (CMS) will be modifying Medicare payment rules for specific interventions for specified Critical Access Hospitals (CAHs) and ambulance services in the following three States: Montana, Nevada, and North Dakota. This demonstration does not exclude any beneficiaries whose Medicare claims are processed by the Railroad SMAC.

CMS will select the participating CAHs prior to July 1, 2016. CMS will identify all providers that will be subject to the payment changes for ambulance services, long term care services, and cost based reimbursement for telehealth services.

B. Policy: CMS is making payment changes for the following service areas for selected critical access hospitals (CAHs):

1. Changes to Payment for CAH Ambulance Services for Providers Participating in the Demonstration only:

CMS regulations at 42 CFR 413.70(b)(5)(B) require that in order for a CAH or a CAH- owned and operated entity to be paid 101 percent of reasonable costs for ambulance services, there can be no other provider or supplier of ambulance services located within a 35-mile drive of the CAH. All other current rules still apply if the provider or suppliers of ambulance services are located outside of the 35-mile range of another CAH.

For identified ambulance services, effective with dates of service on or after July 1, 2016 , a CAH or a CAH-owned and operated entity shall be paid 101 percent of reasonable costs for its ambulance services - *irrespective* of another provider or supplier of ambulance services located within a 35-mile drive of the CAH. The 35 mile waiver shall not include cost-based reimbursement of any new capital (e.g., vehicles) associated with ambulance services.

The MAC shall work with identified CAHs in the demonstration to determine the interim payment amount for ambulance services. The MAC shall use the Ambulance Department Cost-to-Charge Ratio (C/C Ratio) from the prior year Medicare Cost Report to determine reimbursement for the reasonable cost of services according to the current Medicare cost based reimbursement principles. The MAC shall manually adjust the aggregate C/C Ratio for all ancillary departments (Wkst. D. Part V of the Medicare Cost Report) to include

the Ambulance Department C/C Ratio and arrive at a new overall outpatient C/C Ratio under the demonstration. The MAC shall enter this new C/C Ratio into FISS to pay claims during the demonstration. All claim payment information will flow to the PS&R for cost report preparation at year end. Final settlement for reimbursed costs will be conducted at the end of the cost report year according to current MAC settlement procedures.

2. Proposed Changes to Payment for Critical Access Hospitals for Providers Participating in the FCHIP Demonstration only:

Under current statute and regulation, CAHs are allowed no more than 25 beds, which can be used to provide acute or swing bed services. Medicare payment for inpatient services of a CAH is 101 percent of reasonable cost, as determined under applicable Medicare principles of reimbursement. CMS shall identify selected CAHs to receive a waiver of the survey and certification requirements that limit the number of beds in each CAH to no more than 25. The demonstration will allow identified CAHs up to 35 beds; the 10 additional beds shall only be used for nursing facility or skilled nursing level of care.

This expansion of the number of beds (not to exceed 35) shall be reimbursed according to the standard Medicare reimbursement principles for CAHs. Additional capital expenditures will not be allowed under this provision. There are no changes to the methodology for calculating Medicare payments for swing bed services at participating hospitals. The payments in the 10 additional beds shall only be for skilled nursing or nursing facility level of care.

Settlement for any additional costs owed will be conducted at the end of the cost report year according to current MAC settlement procedures. However, at the discretion of the CAHs selected to participate in this intervention, the MAC shall work with the participant CAH on an as needed basis to determine any adjustments to the interim payment amount for Medicare services rendered in the 35 beds.

3. Proposed Policy: Changes to Payment for Telehealth for providers participating in the FCHIP Demonstration only:

Under current Medicare payment rules, a CAH serving as the originating site for a telehealth encounter is paid a separately billable fixed fee according to the physician fee schedule. The distant site provider is also paid a separate fixed fee. Under the FCHIP Demonstration, CMS will pay participating CAH originating sites 101 percent of cost for overhead, salaries, and fringe benefits and the depreciation value of the telemedicine equipment instead of the PFS fixed fee. Medicare payment to distant site practitioners for services furnished using synchronous two-way video technology will not change under the demonstration.

Claim payments for services rendered during the demonstration shall continue to process as a separately billable part B payment. Participating originating site providers will also receive a lump sum payment, in addition to the fee schedule payments, on a quarterly basis to adjust originating site telemedicine payments to reflect 101 percent of cost. The MAC shall consult with identified CAHs to determine the 101 percent of cost of originating site services rendered under the demonstration. The MACs shall follow the process outlined below to make the telemedicine originating site payment changes.

The MAC, in conjunction with CMS, shall amend the cost reports for the participating CAHs, so that the CAHs can report costs associated with providing originating site telemedicine services. CMS will establish a cost center capturing the revenues and expenses associated with these services in the general ledger of the Medicare Cost Reports for demonstration participants. If any of the identified providers do not currently have a telemedicine cost center set up on the cost report for year one of the demonstration, the MAC shall work with them to conduct a time study to estimate direct salary costs applicable to telemedicine services under the demonstration. These studies shall be conducted one week per month with differing weeks in following months. In addition to the time studies, the MAC shall work with providers to estimate overhead allocations, following current Medicare procedures, to be reflected on their cost reports. The MAC shall use this information to develop a C/C Ratio for the telemedicine cost center that includes both direct and indirect

cost.

The MAC shall use the telemedicine claim information pulled from the Paid Claims File and the telemedicine C/C Ratio to convert the revenue from the Fee Schedule amount to a cost based amount. The MAC shall compute the additional lump sum payment amount needed to bring payments up to the cost based amount. The MAC shall make the additional lump sum payments under the demonstration on a quarterly basis through HIGLAS. Final settlement for additional costs owed (based on final cost report information) will be conducted at the end of the cost report year outside of the final cost report settlement.

4. Cost Report years under the Demonstration

The start date for the Demonstration will be July 1, 2016. For the participating CAHs whose cost reporting periods do not coincide with the demosntration start date, the MAC shall determine a methodology so as to allow a July 1, 2016 start date for the payment changes outlined in this Change Request.

5. External audits

The MAC shall review cost reports in accordance with its current auditing practices for CAHs for each participating hospital for the respective service(s) for which it is participating.

CMS will select two separate contractors for this demonstration. The first contractor will monitor the demonstration for overall budget neutrality. The second contractor will perform a more detailed audit of cost expenditures under the demonstration in accordance with standard principles for cost-based reimbursement. These audits shall be used to verify the appropriateness of expended funds, as well as conformity with current regulations. The contractor audit shall be performed independently of the MAC work. The MAC shall cooperate with both CMS contractors, providing infomation about additional lump sum payments, finalized cost reports, and incorporating the audit contractor's determinations regarding cost amounts for the Demonstration into the cost-based payments made to the participating CAHs.

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	
9165.1	CMS will provide to the MAC a list of all CAH CMS Certification Numbers (CCNs) participating in the demonstration, and identify the payment changes that will be applicable to each CAH.									CMS
9165.2	The MAC shall recognize the condition code B2 on ambulance claims for CAHs participating in the ambulance prong of the demonstration, regardless of whether they meet the 35 mile criteria. Ambulance claims with the B2 condition code will process and pay at cost versus fee schedule for those participating in the demonstration.	X								
9165.2.1	Using prior Medicare Cost Report data, the MAC shall	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	determine the ambulance cost to charge ratio and incorporate this ratio into the overall provider cost to charge ratio. The MAC shall update FISS to process all claims at the new rate.									
9165.2.2	The MAC shall provide education to the CAHs in the demonstration to use the B2 condition code on ambulance claims under the demonstration.	X								
9165.2.3	The MAC shall track and report ambulance claims and payment data for providers in the demonstration, using the format provided by CMS.	X								
9165.2.4	The MAC shall provide the report on ambulance claims to CMS and its respective contractors on a quarterly basis. This report shall include, at a minimum, the amount of payments that would have been paid without the demonstration, and the amounts paid under the demonstration.	X								
9165.3	The demonstration will allow identified critical access hospitals up to 35 beds. The 10 additional beds shall only be used for nursing facility or skilled nursing level of care. The MAC shall reimburse Medicare services attributable to the number of beds in the CAH (not to exceed 35) according to the standard Medicare reimbursement principles for CAHs. Claims that overlap cost reporting periods shall not be split. The MAC shall assign them to the cost reporting period for the date of discharge.	X								
9165.3.1	At the discretion of the CAHs selected to participate in this intervention, the MAC shall work on an as needed basis with CAHs selected for this intervention during the first demonstration year to determine any adjustments to the interim payment amount for Medicare services rendered in the 35 beds.	X								
9165.4	For telehealth services currently covered under Medicare Part B, the MAC shall reimburse the originating site providers at 101 percent of cost for overhead, salaries and fringe benefits and the depreciation value of the telemedicine equipment.	X								
9165.4.1	CMS shall amend the cost reports for CAHs participating in this intervention to include a cost center for telemedicine services.									CMS, Cost Report

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9165.4.2	The MAC shall process telehealth HCPCS code Q3014 as customary using fee schedule payments for CAHs participating in the demonstration.	X								
9165.4.3	Participating originating site providers will also receive a lump sum payment, in addition to the fee schedule payments, on a quarterly basis to adjust originating site telemedicine payments to reflect 101 percent of cost. The MAC shall work with identified CAHs to determine the 101 percent of cost of originating site services rendered under the demonstration.	X								
9165.4.3.1	The MAC shall work with participating providers to conduct a time study to estimate direct salary costs applicable to telemedicine services under the demonstration. Time studies shall be conducted one week per month with differing weeks in following months.	X								
9165.4.3.2	In addition to the time study, the MAC shall work with providers to estimate overhead allocations, following current Medicare procedures, to be reflected on their cost reports. The MAC shall use this information, in addition to the information from the time studies, to develop a C/C Ratio for the telemedicine cost center that includes both direct and indirect cost.	X								
9165.4.3.3	On a quarterly basis, the MAC shall pull claims history of those telehealth claims paid on a fee schedule basis during the previous quarter.	X								
9165.4.3.4	The MAC shall use the cost to charge ratio from 9165.4.3.2 and the claims history from 9165.4.3.3 to determine the quarterly lump sum payment amount.	X								
9165.4.3.5	The MAC shall make the quarterly lump sum payment through HIGLAS to the CAH. This shall be a manual process sent via an 835 transaction.	X								
9165.4.3.5.1	In this 835 transaction, the MAC shall include the H1 payment indicator in the HIGLAS POB31 segment to identify the payment type. The MAC shall also include the corresponding dollar amount, and attach a memo with beneficiary level data for the additional	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	lump sum payment.									
9165.4.4	The MAC shall track and report telehealth claims and payment data for providers participating in the demonstration, using the format specified by CMS. This report shall be provided to CMS and its contractors on a quarterly basis.	X								
9165.5	The start date for the Demonstration will be July 1, 2016. For the participating CAHs whose cost report start dates do not coincide with this date, the MAC shall determine a methodology so as to allow a July 1, 2016 start date for the payment changes outlined in this Change Request.	X								
9165.6	The MAC shall review cost reports in accordance with current auditing practices for each participating hospital for the respective service for which it is participating.The audits shall be used to verify the appropriateness of expended funds, as well as conformity with current regulations.	X								
9165.7	The MAC shall provide interim and finalized cost reports and other supporting materials to the audit contractor selected by CMS to perform a more detailed audit of cost expenditures under the Demonstration in accordance with standard principles for cost-based reimbursement.	X								CMS
9165.8	The MAC shall include the determinations of the audit contractor selected by CMS regarding cost amounts that it determines into the cost-based payments made to the participating CAHs for the demonstration.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"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): Siddhartha Mazumdar, 410-786-6673 or siddhartha.mazumdar@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