CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 85	**Date: October 26, 2012**
	Change Request 7898

Transmittal 84, dated August 17, 2012, is being rescinded and replaced by Transmittal 85, dated October 26 2012, which changes the implementation date to October 31, 2012. More time is allowed for the MAC to make appropriate changes. All other information remains the same.

SUBJECT: Revisions to the 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 authorizes an expansion of the demonstration and an extension for an additional 5-year period. This CR makes revisions to CR 7505, which gives instructions for the additional 5-year period.

I. SUMMARY OF CHANGES: This Change Request makes 2 revisions to CR 7505, which specified the payment methodology and method of cost settlement for the Rural Community Hospital demonstration. 1) This CR adds one hospital to the set of hospitals to begin on the first cost report start date on or after April 1, 2011; 2) This CR deletes the requirement stated in CR 7505 that additional payments under section 1109 of the Affordable Care Act be subtracted from the cost-based payment for Medicare inpatient services calculated under the demonstration's payment methodology.

EFFECTIVE DATE: October 1, 2011

IMPLEMENTATION DATE: October 31, 2012

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	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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:

One-Time Notification

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

Attachment – One Time Notification

Pub. 100-19	Transmittal: 85	Date: October 26, 2012	Change Request: 7898

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SUBJECT: Revisions to the 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 authorizes an expansion of the demonstration and an extension for an additional 5-year period. This CR makes revisions to CR 7505, which gives instructions for the additional 5-year period.

Effective Date: October 1, 2011
Implementation Date: October 31, 2012

I. GENERAL INFORMATION

A. 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.

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 program – with a 5-year continuation period for each hospital. In addition, a new set of hospitals was selected to begin the demonstration. Each of these hospitals will participate for a period of 5 years, beginning on the first cost report start date on or after April 1, 2011. The period of performance will conclude December 31, 2016.

This change request makes 2 revisions to CR 7505, which specified the payment methodology and method of cost settlement for the demonstration:

1) This CR adds one hospital to the set of hospitals to begin on the first cost report start date on or after April 1, 2011. This hospital was omitted from CR 7505 in order to begin its operational participation in the demonstration concurrent with the implementation of the Jurisdiction H Medicare Administrative Contractor.
2) This CR eliminates the requirement stated in CR 7505 that additional payments under section 1109 of the Affordable Care Act, to be made to certain of the hospitals participating in the demonstration, be subtracted from the cost-based payment for Medicare inpatient services calculated under the demonstration's payment methodology.

B. Policy:

1. CR 7505 identified a set of newly participating hospitals to receive reasonable cost payment for inpatient services for the first cost reporting period starting on or after April 1, 2011. One hospital that was selected for the demonstration was omitted from this list of hospitals – in order for it to begin

participation concurrent with the implementation of the Jurisdiction H Medicare Administrative Contractor.

This hospital is Marion General Hospital in Columbia, Mississippi (Provider number – 250085). Cost-based payment according to the payment methodology for the demonstration will begin with the base year – 10/1/11 – 9/30/12. The JH MAC will use cost report information for the period- 10/1/11 – 9/30/12.

2. BR 7505.20 requires that the MAC or FI subtract the amount paid under section 1109 of the Affordable Care Act from the cost-based payment for Medicare inpatient services calculated under this demonstration methodology. This CR is cancelling these instructions. The MAC or FI will not subtract these amounts received by participating hospitals from the cost-based payments for the demonstration.

3. All other requirements for CR 7505 will remain in effect.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement.
Use "Should" to denote an optional requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7898.1.1	The JH MAC shall begin reasonable cost payment for Medicare inpatient services for Marion General Hospital in Columbia, Mississippi (Provider number – 250085) for its first, base year – 10/1/11 – 9/30/12.	X									
7898.1.2	The JH MAC shall use cost report information for the period- 10/1/11 – 9/30/12 to determine the base year reasonable cost amount.	X									
7898.2	The MAC or FI shall not subtract the amount paid under section 1109 of the Affordable Care Act from the cost-based payments for the demonstration.	X		X							
7898.3	All other requirements for CR 7505 shall remain in effect.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sid Mazumdar at siddhartha.mazumdar@cms.hhs.gov, or call (410) 786-6673

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.