CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 104	**Date: May 23, 2014**
	Change Request 8683

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

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. CMS will be modifying payment rules for Medicare payment for providers in no more than four States, among Alaska, Montana, Nevada, North Dakota, and Wyoming. Medicare payment changes will occur for Critical Access Hospitals and ambulance services from no more than four of these States. CMS will select the affected providers through a competitive process and announce these to the MAC prior to October 1, 2014.

A separate CR will be submitted for an intervention that will implement policy changes for home health payment to demonstration providers.

EFFECTIVE DATE: October 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2014

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 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:
Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 104	Date: May 23, 2014	Change Request: 8683

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

EFFECTIVE DATE: October 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2014

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. . CMS will be modifying payment rules for Medicare payment for selected providers in no more than four States, among Alaska, Montana, Nevada, North Dakota, and Wyoming.

CMS will soon submit a separate change request with instructions for the home health intervention, which will require a system change.

CMS will notify the MAC and shared systems maintainers which providers will participate in the demonstration.

B. Policy: CMS is making payment changes for the following services:

- CMS is increasing the bed size limits for CAHs from 25 to 35.The additional beds will only be used for nursing facility services. This payment change will only apply to selected CAHs that meet certain survey and certification requirements.

- CMS will modify Medicare reimbursement for telehealth so that the reimbursement for the originating site providers, so long as it is a CAH, will be made on the basis of cost-based reimbursement. This will require amended cost reports.

- CMS will waive the 35 mile rule for cost-based reimbursement of ambulance services furnished by a CAH or by an entity that is owned and operated by the CAH in these frontier communities to allow for cost-based reimbursement for ambulance services furnished by CAHs participating in the demonstration, even if there is another ambulance service within a 35-mile drive of the CAH or the entity owned and operated by the CAH. Under such circumstances, cost-based reimbursement will be allowed, but not for any new capital (e.g., vehicles) associated with ambulance services.

CMS will select the providers for each of these respective interventions and identify them to the MAC prior to October 1, 2014.

- In addition, CMS is adding a separate reimbursement for mileage for home health services. Since this will require a system change, CMS will be providing these instructions in a subsequent change request, to be effective January 1, 2015.

Current Policy: CAH Ambulance Services

Prior to October 1, 2014, CMS regulations at 42 CFR 413.70(b)(5)(B) require in order for a CAH or a CAH-owned and operated entity to be paid 101 percent of reasonable costs for its ambulance services, there can be no other provider or supplier of ambulance services located within a 35-mile drive of the CAH.

Proposed Policy: Changes to Payment for CAH Ambulance Services for Providers Participating in the Demonstration only:

For identified ambulance services, effective with dates of service on or after October 1, 2014, a CAH or a CAH-owned and operated entity ***shall*** be paid 101 percent of reasonable costs for its ambulance services - *irrespective* of 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.

Current Policy: Critical Access Hospital Payment Changes

Under statute and regulation, critical access hospitals 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.

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

CMS shall identify critical access hospitals that will be subject to this policy change. For this policy change, these hospitals will be certified according to the State's health and survey agency. The demonstration will allow identified critical access hospitals up to 35 beds. The 10 additional beds shall only be used for nursing facility level care.

Medicare services attributable to the number of beds in the critical access hospital (not to exceed 35) shall be reimbursed according to the standard Medicare reimbursement principles for critical access hospitals.

Current Policy: Changes to Payment for Telehealth

The originating site facility fee is a separately billable Part B payment. The contractor pays this fee outside of other payment methodologies. The originating site facility fee is the lesser of $24.63 or the actual charged. The originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final rules published by November 1 prior to the calendar year for which it will be effective. When the originating site is a critical access hospital, payment is separate from the cost-based reimbursement methodology. The amount is 80 percent of the originating site facility fee.

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

- This demonstration will only affect Medicare payment changes to reimbursement for currently covered services from the originating site. CMS will reimburse these providers at 101 percent of cost for overhead, salaries and fringe benefits and the depreciation value of the telemedicine equipment.

- CMS will identify the CAHs to participate in this policy change.

- CMS shall amend the cost reports for the participating CAHs, so that the CAHs will be able to report costs associated with providing originating site telemedicine services.

- The MAC will make this cost payment for telehealth originating site services based on the information provided on the amended cost report.

- The change to the current part B payment (to include cost based payment for the originating site) will be incorporated in the interim payment. Settlement will be conducted at the end of the cost report year.

Current Policy: Changes to payment for Asynchronous Technology for Providers participating in the FCHIP Demonstration only

Currently, an interactive telecommunications system is required as a condition of payment. The use of asynchronous "store and forward" technology is only allowed distant site providers who participate in Federal telemedicine demonstration projects in Alaska or Hawaii.

Proposed Policy: Changes to Asynchronous Technology

- This demonstration will only effect changes to reimbursement for the distant site provider for use of covered services for store and forward technology. Reimbursement for these services shall be limited to the current Medicare reimbursement for these services.

- CMS shall identify the CAH and the distant site providers that will be participating in order to properly identify these claims.

External audits

The MAC shall conduct audits for each participating hospital for their respective service for which they are participating. The audits shall be used to verify the appropriateness of expended funds, as well as conformity with current regulations.

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	
8683.1	Proposed Policy: Changes to Payment for CAH Ambulance Services For identified ambulance services, effective with dates of service on or after October 1, 2014, a CAH or a CAH-owned and operated entity *shall* be paid 101 percent of reasonable costs for its ambulance services - *irrespective* of other provider or suppliers 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.	X								CMS, Cost Report, MedPar, NCH, Providers
8683.2	Proposed Changes to Payment for Critical Access	X								CCSQ, CMS,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Hospitals CMS shall identify critical access hospitals that will be subject to this policy change. For this policy change, these hospitals will be certified according to the State's health and survey agency. The demonstration will allow identified critical access hospitals up to 35 beds. The 10 additional beds shall only be used for nursing facility level care. Medicare services attributable to the number of beds in the critical access hospital (not to exceed 35) shall be reimbursed according to the standard Medicare reimbursement principles for critical access hospitals.									Cost Report, Hospital, MedPar, NCH, PS&R, Providers
8683.3	Proposed Policy: Changes to Asynchronous Technology • This demonstration will only effect changes to reimbursement for the distant site provider for use of covered services for store and forward technology. Reimbursement for these services shall be limited to the current Medicare reimbursement for these services. • CMS shall identify the CAH and the distant site providers that will be participating in order to properly identify these claims.	X								CMS, Hospital, MedPar, NCH, PS&R, PSC, Providers
8683.4	**External audits** The MAC shall conduct audits for each participating hospital for their respective service for which they are participating. The audits shall be used to verify the appropriateness of expended funds, as well as conformity with current regulations.	X								CMS, Cost Report, Hospital
8683.5	Proposed Policy: Changes to Payment for Telehealth - Cost-based Payment for Originating Site • This demonstration will only affect Medicare payment changes to reimbursement for currently covered services from the originating site. CMS will reimburse these providers at 101 percent of cost for overhead, salaries, and fringe benefits, as well as the depreciation value of the telemedicine equipment.	X								Cost Report, Hospital, JE A/B MAC, NCH, PS&R, Providers

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• CMS will identify the participating CAHs. • CMS shall amend the cost reports for the participating CAHs, so that the CAHs will be able to report costs associated with providing the originating site telemedicine services. • The MAC will make this cost payment for the telehealth originating site services based on the information provided on the amended cost report. • The current part B payment including the payment based on cost for the originating site shall be incorporated as part of the interim payment. The cost report settlement process will occur after the cost report is submitted.									

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: N/A

"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): Steven Johnson, 4107863332 or steven.johnson@cms.hhs.gov, Siddhartha Mazumdar, 4107866673 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.

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