CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 86	**Date: December 21, 2012**
	Change Request 8076

NOTE: This instruction is being re-communicated to correct the implementation date to January 22, 2013. The instruction has been revised. The transmittal number, date issued and all other information remain the same.

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

I. SUMMARY OF CHANGES: Both the Hospital Value-Based Purchasing Program and the Hospital Readmission Reduction Program will apply to the hospitals participating in the Rural Community Hospital demonstration.This Change Request clarifies the methodology according to which payment enhancements (possible for the HVBP) programand payment reductions (possible forboth the HVBP and Hospital Readmission Reduction Program) will be calculated and implemented for the hospitals participating in the demonstration.

EFFECTIVE DATE: October 2, 2011
IMPLEMENTATION DATE: January 22, 2013

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) and/or Carriers:
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

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

EFFECTIVE DATE: October 2, 2011

IMPLEMENTATION DATE: January 22, 2013

I. GENERAL INFORMATION

A. Background:

Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated a demonstration that establishes rural community hospitals, which receive reimbursement for inpatient services according to a cost-based methodology.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 (ACA) both expanded and extended the demonstration for an additional 5-year period.There are currently 23 hospitals participating in the demonstration – 7 were selected between 2004 and 2008, while 16 are participating as a result of the ACA expansion.The period of performance will conclude December 31, 2016.

As authorized by section 3001(a) of the ACA, CMS has implemented the Hospital Value-Based Purchasing Program, under which value-based incentive payments are made in a given fiscal year to hospitals meeting performance standards specified by CMS for that fiscal year.The value-based incentive payment will be applied to discharges beginning October 1, 2012.

Sections 3025 and 10309 of the ACA established the Hospital Readmissions Reduction Program, which is effective for discharges from an applicable hospital beginning October 1, 2012.

Both the Hospital Value-Based Purchasing Program (HVBP) and the Hospital Readmission Reduction Program will apply to the hospitals participating in the Rural Community Hospital demonstration.This Change Request clarifies the methodology according to which payment enhancements (possible for the HVBP) program and payment reductions (possible forboth 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.

B. Policy: Hospital Value-Based Purchasing Program

For each hospital participating in the demonstration -

1.For each hospital cost report year, the hospital's payment for covered inpatient services, net of any adjustments for the HVBP Program and Hospital Readmission Reductions Program, will be determined according to the methodology outlined in CR 7505, as amended by CR 7898.All provisions of CR 7505remain in effect, except for those amended by CR 7898.

2.For this CR, the applicable cost periods are those for which the hospital participates in the demonstration that contain discharges occurring on or after October 1, 2012, which includes cost report period that begin after October 1, 2011 and end on or before December 31, 2016 (the end date of the demonstration).

3.According to section 3001(a) of the ACA, the Hospital Value-Based Purchasing Program applies to subsection (d) hospitals, with certain exceptions.Hospitals participating in the Rural Community Hospital demonstration will be included in the HVBP Program, because they are subsection (d) hospitals.

4.CMS will determine exceptions for individual hospitals on the basis of rules specific to the HVBP program.Participation in the demonstration does not exempt a hospital from participation in the HVBP program.

5.The regulations that implement the HVBP Program are in subpart I of 42 CFR part 412 (412.160 through 412.167).In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentivepayment adjustment factor.

6.According to CR 8041, CMS will not begin to implement the value-based incentive payment adjustments until January 2013.

7.For each hospital participating in the Rural Community Hospital demonstration that is eligible for the HVBP Program –

a) CMS will calculate a value-based incentive payment adjustment factor that is to be applied to the base operating DRG payment amount for each discharge – as if the hospital were paid under the IPPS. This calculation will be made for each federal fiscal year according to the rules for the HVBP program.

b) The MAC will calculate the value-based payment adjustment amount for the applicable cost report period for the hospital(this amount is X).This amount is calculated by applying the value-based incentive payment adjustment factor for the applicable Federal FY to the base operating DRG payment amount for all discharges in that Federal FY included in the cost report year.

8.The MAC will subtract this amount (X) (if it is a reduction) from or add the amount (X) (if it is a value-based incentive payment adjustment) to the payment amount for inpatient hospital services that is determined according to the methodology outlined in CR 7505, as amended by CR 7898 (Y).This amount (X) will be subtracted from or added to the reimbursement amount (Y) for the applicable cost report periods - beginning after October 1, 2011. This adjustment will occur at cost report settlement.

<u>Hospital Readmissions Reduction Program</u>

9.Section 3025 of the ACA established the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to applicable hospitals with excess readmissions, effective for discharges occurring on or after 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).

10.In the FY 2013 IPPS/LTCH PPS final rule CMS finalized that subsection (d) hospitals are subject to the Hospital Readmissions Reduction Program.Hospitals participating in the Rural Community Hospital demonstration will be subject to the Hospital Readmissions Reduction Program because they are subsection (d) hospitals.

11.The methodology to calculate readmissions payment adjustment factors is discussed in the FY 2013 IPPS/LTCH PPS final rule.For hospitals participating in the Rural Community Hospital demonstration, the readmissions adjustment factor is applied in accordance with CR 8041, as if the hospital were paid under the IPPS.

12.CMS calculates a readmissions payment adjustment factor that is applied to a hospital's base operating DRG payment amount for each discharge occurring during the Federal FY as if the hospital were paid under the IPPS.This calculation will be made for each Federal FY according to the rules for the Hospital Readmission Program.

13.For hospitals participating in the Rural Community Hospital demonstration, the MAC will calculate the amount of the readmissions payment reduction (X) for the applicable cost report period for the hospital.This amount is calculated by applying the readmissions payment adjustment factor forthe applicable Federal FY to the base operating DRG payment amount for all discharges in that Federal FY included in the cost report year.

14.The MAC will subtract this amount (X) from the payment amount for inpatient hospital services that is determined according to the methodology outlined in CR 7505, as amended by CR 7898 (Y). This amount (X) will be subtracted from the reimbursement amount(Y) for the applicable cost report periods – that is those cost reporting periods that contain discharges occurring on or after October 1, 2012, which includes cost report periods beginning after October 1, 2011.This subtraction will occur at cost report settlement.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8076.1	CRs 7505 and 7898 identify participating hospitals in the Rural Community Hospital demonstration.CMS has identified hospitals that have withdrawn in communication to the specific MACs.											CMS CM MI
8076.2	For each hospital cost report year, the MAC shalldetermine the participating hospital's payment for covered inpatient services according to the methodology outlined in CRs 7505 and 7898.This amount is net of adjustments for the HVBP program and Hospital Readmission Reduction program.	X										
8076.3	CMS shall calculate a value-based incentive payment adjustment factor that the MAC will apply to the base operating DRG payment amount for each dischargeas if the hospital were paid under the IPPS.This calculation will be made for each federal fiscal year according to the rules for the HVBP program.											CMS CM
8076.4	The MAC shall calculate the value-based payment adjustment amount for the applicable cost report period for the hospital(This amount is X).This amount is calculated by applying the value-based incentive payment adjustment factor for the applicable federal	X										

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	fiscal year to the base operating DRG payment amount over all discharges in the cost report year. For this CR, the applicable cost report periods are those for which the hospital participates in the demonstration - that begin after October 1, 2011 and conclude on or before December 31, 2016.											
8076.5	The MAC shall subtract this amount (X) (if it is a reduction) or add the amount (X) (if it's a value-based incentive payment adjustment) from or to the payment amount for inpatient services that is determined according to the methodology outlined in CR 7505, as amended by CR 7898 (Y).This addition or subtraction will occur at cost report settlement.For this CR, the cost report periods affected are those for which the hospital participates in the demonstration beginning after October 1, 2011 and ending on or before December 31, 2016.	X										
8076.6	CMS shall calculate the readmission adjustment factor for each hospital in accordance with CR 8041, as if the hospital were paid under the IPPS.											CMS CM
8076.7	The readmission adjustment factor is applied to the hospital's base operating DRG amount to determine the amount reduced from a hospital's inpatient payment due to excess readmissions (X).											CMS CM
8076.8	For hospitals participating in the Rural Community Hospital demonstration, the MAC shall calculate the amount of reduction (X)and apply it to the payment amount for inpatient services that is determined according to the methodology outlined in CR 7505, as amended by CR 7898 (Y)for the hospital's cost reporting periods for which the hospital participates in the demonstration beginning after October 1, 2011 and ending before December 31, 2016.The MAC will make this reduction at cost report settlement.	X										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8076.9	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X						

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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 Mazumdar, 410-786-6673 or Siddhartha.Mazumdar@cms.hhs.gov

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), and/or Carriers:
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Section B: For Medicare Administrative Contractors (MACs):
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