Acute Inpatient Prospective Payment System (IPPS)

1. Obtained IPPS wage indices for 2013 thru 2019 from https://www.cms.gov/
2. Obtained provider county from the Provider of Service (POS)
3. Convert prior CBSA wage indices to state/county by merging with County crosswalk files
4. NCH records
    a. Keep only inpatient claims – claim type 60 and the 50 U.S. states plus the District of Columbia, minus Maryland (and plus Puerto Rico, starting January 1, 2016)
    b. Includes acute care hospitals – range 0001 thru 0879
    c. Determine provider state and county per POS
    d. Determine wage index based on provider state and county
    e. AND CLM_TOT_CHRG_AMT > 0 AND CLM_MCO_PD_SW NE '1'
    f. AND SUBSTR(PROVIDER_NUMBER,3,1) EQ '0'
    g. AND SUBSTR(PROVIDER_NUMBER,5,1) NE 'V'
    h. AND SUBSTR(PROVIDER_NUMBER,6,1) NOT IN ('E','F')
    i. AND SUBSTR(PROVIDER_NUMBER,3,3) NOT IN ('897','898','899','998','999')
    j. AND PROVIDER_NUMBER NOT IN ('050146','050660','220162','330154','330354','360242', '390196','450076','100079','100271','500138')
    k. AND PROVIDER_NUMBER NOT IN (SOLE_COMM_HOSP);

Table 1: IPPS Labor Percentage

Fiscal Year	Greater than 1		Less than 1	
	Labor	Non-Labor	Labor	Non-Labor
2013	0.688	0.312	0.62	0.38
2014	0.696	0.304	0.62	0.38
2015	0.696	0.304	0.62	0.38
2016	0.696	0.304	0.62	0.38
2017	0.696	0.304	0.62	0.38
2019	0.683	0.317	0.62	0.38

		CLM PMT AMT	$10,247		Claim payment amount from NCH
	+	DEDUCTABLE AMT	$1,132		Beneficiary inpatient deductible amount
	+	COINSURANCE AMT	$0		Beneficiary Part A coinsurance liability amount
		NET PAYMENT	$11,379		Claim payment plus deductible and coinsurance
×					
(		NAT LABOR PCT	0.62		Labor related share
	×	CURR INDEX	0.7477		Current wage index
	+	NON-LABOR PCT	0.38	)	Non-labor related share
			0.84		Current wage ratio: (0.62 × 0.7477 + 0.38) = 0.84
÷					
(		NAT LABOR PCT	0.62		Labor related share
	×	PREV INDEX	0.8112		Prior wage index
	+	NON-LABOR PCT	0.38	)	Non-labor related share
			0.88		Prior wage ratio: (0.62 × 0.8112 + 0.38) = 0.88
		NEW WAGE RATIO	0.96		New wage ratio = (0.84 / 0.88)
	×	ADJ PAYMENT	$10,872		Adjusted payment = $11,379 × (0.84 / 0.88)
	−	DEDUCTABLE AMT	$1,132		Beneficiary inpatient deductible amount
	−	COINSURANCE AMT	$0		Beneficiary Part A coinsurance liability amount
		NEW PAYMENT	$9,740		New payment amount including adjustment

This method is adjusting the claim payment amount from NCH, which includes the DRG outlier approved payment amount, disproportionate share, indirect medical education, and total PPS capital. It does not include pass-thru amounts, beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Puerto Rico Specific Wage Index and National Rate Adjustment

Section 601 of Public Law 114-113, The Consolidated Appropriations Act of 2016, modified the Inpatient Prospective Payment System (IPPS) payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico (PR) hospital for inpatient hospital discharges on or after January 1, 2016, to use 100 percent of the applicable Federal payment rate.

To reflect this in the Medicare Advantage capitation rates, IPPS claim payment amounts are adjusted to incorporate the new applicable rate as well as apply the current wage index. To accomplish this, the deductible and coinsurance amounts are first added to the claim payment, and the capital, disproportionate share (DSH), Indirect Medical Education (IME), and outlier amounts are subtracted. This applicable payment is then inflated to bring the PR rate up to the Federal level.

The inflation of this modified payment amount is dependent on the dates of service for PR hospitals. Therefore, "add-on" amounts are calculated based on the national standardized amount (xP) and the Puerto Rico standardized amount (P).

New Payment Piece = .25×.68×xP×wi+.25×.32×xP
Old Payment Piece = .25×.68×P×pwi+.25×.32×P

0.17 Labor share
0.08 Non-labor share

Table 1: Add-on amounts for Puerto Rico specific IPPS adjustment

	National Amount	PR Amount	National add-on	PR add-on			Non-labor Add-on
FY	xP	P	0.17×xP	0.17×P	0.08×xP	0.08×P	Delta
2016[1]	5467.39	2610.77	929.4563	443.8309	437.3912	208.8616	228.5296
2015	5437.85	2547.42	924.4345	433.0614	435.0280	203.7936	231.2344
2014	5370.28	2545.72	912.9476	432.7724	429.6224	203.6576	225.9648
2013	5348.76	2518.79	909.2892	428.1943	427.9008	201.5032	226.3976
2012	5209.74	2501.27	885.6558	425.2159	416.7792	200.1016	216.6776
2011	5164.11	2444.67	877.8987	415.5939	413.1288	195.5736	217.5552

After the "add-on" amounts are calculated for each time period, they are applied to the modified payment amount using the prior year wage index and current year PR specific wage index. For dates of service from October 1, 2015 to December 31, 2015, the formula would be as follows:

Applicable Payment + 929.4563 × FY 2016 Wage Index – 443.8309 × FY 2017 PR index + 228.5296

Once the modified payment amount has been inflated to reflect the 100 percent national level, that amount is used to adjust the IME and DSH payments as well as the labor related share based on the current year wage index in order to bring prior year claim dollars up to current levels. As such, this adjustment only applies to calendar years 2012 – 2015.

[1] The row for FY 2016 is only for the first quarter of fiscal year 2016. Starting January 1, 2016, the "add-on" adjustment is not necessary.

PR National Rate Adjustment Example

	Claim Payment Amount	$14,739
+	Deductible	$1,216
+	Coinsurance	$0
−	Indirect Medical Education	$0
−	Disproportionate Share	$150
−	Uncompensated Care Payment	$4,382
−	Outlier Amount	$0
(	Modified PR Payment	$11,422
+	National add-on	$913
	× IPPS DRG Weight	3.3576
	× Current National Wage Index	0.4318
−	Puerto Rico add-on	$433
	× IPPS DRG Weight	3.3576
	× Current PR Specific Wage Index	1.0069
+	Non-labor add-on	$226
	× IPPS DRG Weight	3.3576)
	PR PPS Amount	$12,041
÷	Modified PR Payment	$11,422
	PR PPS Ratio	1.0542
	Indirect Medical Education	$0
×	PR PPS Ratio	1.0542
	New Indirect Medical Education	$0
	Disproportionate Share	$150
×	PR PPS Ratio	1.0542
	New Disproportionate Share	$158
	PR PPS Amount	$12,041
−	Deductible	$1,216
−	Coinsurance	$0
+	New Indirect Medical Education	$0
+	New Disproportionate Share	$158
+	Uncompensated Care Payment	$4,382
+	Outlier Amount	$0
	PR 100% National Adjustment	$15,366

PR Wage Index Adjustment Example

		PR 100% National Adjustment	$15,366	
	+	Deductible	$1,216	
	+	Coinsurance	$0	
			$16,582	
×				
(		Labor related share	0.62	
	×	Current wage index	0.418	
	+	Non-labor related share	0.38	)
		Current wage ratio	0.64	
	÷			
(		Labor related share	0.62	
	×	Prior wage index	0.4318	
	+	Non-labor related share	0.38	)
		Prior wage ratio	0.65	
		New wage ratio	0.99	
	×	Adjusted payment	$16,363	
	−	Deductible	$1,216	
	−	Coinsurance	$0	
		New payment	$15,147	
		Percent Impact	3%	

Skilled Nursing Facility Prospective Payment System

1. Obtained SNF wage indices for 2013 thru 2019 from https://cms.gov
2. Obtained provider county from the Provider of Service (POS) file
3. Convert prior year CBSA wage indices to state/county by merging with County crosswalk files
4. NCH records
    a. Keep only SNF claims - claim type 20 or 30
    b. Include provider range 5000 thru 6499
    c. Determine provider state and county per POS
5. Apply wage adjustment
    a. Apply Urban/Rural wage index by state and county
    b. Use the appropriate labor percentage from Table 2
    c. Apply wage index adjustment

Table 2: SNF Labor Percentage

2013	0.68693
2014	0.69545
2015	0.69180
2016	0.69100
2017	0.68800
2018	0.70800
2019	0.70500

	CURR INDEX	0.7121	SNF PPS wage index of current year
−	PREV INDEX	0.7327	SNF PPS wage index of prior year
	NET INDEX	−0.0206	Difference between current and prior wage index
×	LABOR SHARE	0.7050	Labor related share
	WAGE INDEX ADJ	−0.01452	Wage difference times labor related share
	NAT LABOR	0.7050	Labor related share
×	PREV INDEX	0.7327	SNF PPS wage index of prior year
	WAGE ADJ FACTOR	0.5166	Previous index times labor related share
	1	1	
−	LABOR SHARE	0.7050	Labor related share
	NONLABOR SHARE	0.2950	Non-labor related share
	CLM PMT AMT	5507.85	Claim payment amount from NCH
÷	TOT ADJ FACTOR	0.8116	Wage payment adjustment factor plus non-labor share
	BASE PMT RATE	$6,786	Claim payment times payment adjustment factor
×	WAGE INDEX ADJ	−0.01452	Wage difference times labor related share
	ADJ PMT AMT	−$99	Final adjustment to claim payment amount
+	CLM PMT AMT	$5,508	Claim payment amount from NCH
	NEW PMT AMT	$5,409	New payment amount including adjustment

Home Health Prospective Payment System (HH PPS)

1. Obtained HH-PPS CBSA wage indices for 2013 thru 2019 from CM
2. Convert prior year CBSA wage indices to state/county by merging with County crosswalk files
3. NCH records
    a. Keep only HH-PPS claims - claim type 10
    b. Include claims with a type of bill equal to 32 or 33 and claim frequency code not equal to 0 or 2
    c. Drop DME claim lines paid under fee schedule where revenue center not equal 029*x*, 060*x*, or 0274
    d. Add wage index to claims by beneficiary SSA state and county from claim
    e. Use the appropriate labor percentage from Table 3.
    f. Sum claim lines to the claim level
    g. Apply adjustment

Table 3: HHA Labor Percentage

2013	0.78535
2014	0.78535
2015	0.78535
2016	0.78535
2017	0.78535
2018	0.78535
2019	0.76100

		CLM PMT AMT	$1,443	Claim payment amount from NCH
×				
(		NAT LABOR PCT	0.78535	Labor related share
	×	CURR INDEX	0.8017	Current wage index
	+	NON-LABOR PCT	0.21465)	Non-labor related share
			0.844	Current wage ratio: (0.78535 × 0.8017 + 0.21465) = 0.844
÷				
(		NAT LABOR PCT	0.78535	Labor related share
	×	PREV INDEX	0.8159	Prior wage index
	+	NON-LABOR PCT	0.21465)	Non-labor related share
			0.855	Prior wage ratio: (0.78535 × 0.8159 + 0.21465) = 0.855
		NEW WAGE RATIO	0.987	New wage ratio = (0.844 / 0.855)
	×	ADJ PAYMENT	$1,424	Adjusted payment = $1,443 × (0.844 / 0.855)

This method is adjusting the claim line payment amount from NCH, which includes the HH-PPS outlier approved payment amount**.**

Physician Fee Schedule

1. Obtained 2013 - 2019 relative value units (RVUs) and geographic practice cost indexes (GPCIs) from CM for all jurisdictions.
2. NCH Records
    a. Extracted physician claim lines with claim types 71 or 72
    b. Added RVUs to each claim line by HCPCS code and first modifier code
    c. Added GPCIs to claim based on contractor and locality
    d. Use the appropriate facility or non-facility practice expense RVU
        i. Facility is where the place of service equals one of the following
            21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 61, 56
    e. Multiply the previous RVU by the previous GPCI for work, practice, and malpractice expenses
    f. Multiply the previous RVU by the current GPCI for work, practice, and malpractice expenses. The current GPCI is the final 2019 GPCIs for all provider locations.
    g. Divide the current rate by the previous rate to obtain a percent difference
    h. Multiply the percent difference by the line payment, resulting in the final adjustment value
    i. Added the final adjustment value to the line payment to obtain an adjusted payment

		Work		Practice Expense		Malpractice		RVU × GPCI Sum	
Previous									
RVU		1.16		0.68		0.07			
GPCI	×	1		1.046		0.658			
		1.16	+	0.71128	+	0.04606	=	1.91734	Prior year payment rate
Current									
RVU		1.16		0.68		0.07			
GPCI	×	0.99		1.044		0.86			
		1.1484	+	0.70992	+	0.0602	=	1.91852	Current year payment rate
							÷	0.0615%	Percent difference of payment rates
							×	$43.26	Line payment amount from NCH
								$0.03	Final adjustment to claim payment
							+	$43.26	Line payment amount from NCH
								$43.29	New payment including adjustment

The GPCIs measure geographic differences in physician wages, wages of clinical and administrative staff, cost of contracted services (e.g. accounting and legal services), cost to rent office space, and the cost of professional liability insurance. The GPCIs assume that medical supplies (including pharmaceuticals) and medical equipment are purchased in national markets and no geographic adjustment is made for these components of a physician practice.

Outpatient Prospective Payment System (OPPS)

1. Obtained IPPS wage indices for 2013 thru 2019 from https://www.cms.gov/
2. Obtained provider county from the Provider of Service (POS) file
3. Convert prior year CBSA wage indices to state/county by merging with County crosswalk files
4. NCH records
    a. Keep only outpatient claims - claim type 40
    b. Limit to OPPS claims where status code equals P, S, T, V, J1, or J2
        i. In addition, status code of X thru 2014
    c. Determine provider state and county per POS
5. Apply wage adjustment
    a. Use provider reclassification if it exists
    b. Else use Urban/Rural state/county index
    c. Removed prior year wage index
    d. Calculate current year wage ratio
    e. Apply wage index adjustment

	LINE PMT AMT	$97.65	Line payment amount from NCH
÷	(.6 × WAGE INDEX + .4)	0.90526	Remove prior year wage index
	UNADJSTD PMT	$107.87	Unadjusted payment amount
	(.6 × WAGE 2019 + .4)	0.90364	Apply current year wage index
×	UNADJSTD PMT	$107.87	Unadjusted payment amount
	NEW PMT AMT	$97.48	New payment amount including adjustment

This process is adjusting the labor related portion of the standard OPPS national unadjusted payment rates to account for geographic wage differences. These wage indexes are the same as those in the fiscal year based IPPS, but adopted into the OPPS on a calendar year basis. Certain services such as those with status indicators of G, H, K, R, and U are not adjusted by a wage index, as the payment does not include a labor related portion (I.e. G and K represent drugs, H is devices, R is blood and blood products, U is brachytherapy sources).

ESRD Prospective Payment System (ESRD PPS)

4. Obtained ESRD PPS CBSA wage indices for 2014 thru 2019 from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment
5. Convert prior year CBSA wage indices to state/county by merging with County crosswalk files
6. Apply wage adjustment to ESRD PPS amounts only
    a. Keep only claims ESRD PPS for Dialysis Facilities - include claims with a claim type 40 and type of bill equal to 72*x*
    b. Adjust only lines paid under ESRD Dialysis PPS - revenue center equal 0821, 0831, 0841, 0851, and 0881
    c. Add wage index to claims by beneficiary SSA state and county from claim
    d. Use the appropriate labor percentage from Table 4
    e. Calculate current year wage ratio using most recent wage index and labor percentage
    f. Calculate prior year wage ratio using prior wage index and labor percentage
    g. Apply wage index adjustment

Table 4: ESRD PPS Labor Percentage

2014	0.41737
2015	0.46205
2016	0.50673
2017	0.50673
2018	0.50673
2019	0.52300

	CLM LINE PMT AMT	$1,443		Claim line payment amount from NCH
×				
(	NAT LABOR PCT	0.50673		Labor related share
×	CURR INDEX	0.9041		Current wage index
+	NON-LABOR PCT	0.49327	)	Non-labor related share
		0.95140		Current wage ratio: (0.50673 × 0.9041 + 0.49327) = 0.9514
÷				
(	NAT LABOR PCT	0.50673		Labor related share
×	PREV INDEX	0.9256		Prior wage index
+	NON-LABOR PCT	0.49327	)	Non-labor related share
		0.96230		Prior wage ratio: (046205 × 0.9256 + 0.53795) = 0.96230
	NEW WAGE RATIO	0.98867		New wage ratio = (0.95140 / 0.96230)
×	ADJ PAYMENT	$1,427		Adjusted payment = $1,443 × (0.95140 / 0.96230)

This method is adjusting the claim line payments for ESRD PPS line items adjusted by the ESRD wage index.

Competitive Bid Program for
Durable Medical Equipment Prosthetic Orthotics Supplies (DMEPOS)

OACT calculates Managed Care payment amounts for CY2020 based on the 5-year average of Fee-For-Service (FFS) claims from CY2013 to CY2017. The historical FFS claim payment amounts represent the payment methods that were in place during that time period. In order to appropriately set MA Ratebook amounts that reflect the payment methods consistent with the MA bid year to which the rates will be applied, we have developed a process to adjust the DMEPOS Claims to account for the changes in the prices associated with the Competitive Bidding Program (CBP). The CBP requires DMEPOS suppliers to submit bids for selected products in designated Competitive Bidding Areas (CBAs) in order to provide access to quality items create incentives to for appropriate payments. In order to reflect the new single payment amounts (SPA) for DMEPOS in the base years, we use the following methodology to re-price DMEPOS claims for each year 2013 to 2017 for all HCPC codes associated with the CBP and:

1. Download single payment amounts for DMEPOS for the most recent Round 1, Round 2 and National Mail Order HCPCS codes including geographic areas and product categories from the Competitive Bidding website located at http://www.dmecompetitivebid.com. These amounts are increased by the factor (CPI-U January 2019 / CPI-U January 2018).
2. Create a re-pricing table combining all DMEPOS items and geographic areas.
3. Identify FFS DMEPOS payments using National Claims History (NCH) Records as loaded into Integrated Data Repository (IDR)
    a. Extract DME claim lines with claim type 72, 81 or 82.
    b. Determine whether DME claim line HCPCS code is subject to competitive bidding.
    c. Determine if DME claim is subject to competitive bidding based on zip code from the NCH.
    d. Include only Fee-for-Service claims.
    e. Exclude ESRD beneficiaries (beneficiary with active dialysis period at time of service.)
    f. Exclude Beneficiaries enrolled in MAO Cost Plans.
    g. Calculate Medicare maximum payment by multiplying allowed charge amount by the share to be borne by Medicare, or 77.8%.
4. Determine the re-priced payment amount for DMEPOS Competitive Bidding by multiplying the single payment amounts (for the HCPCS code in the geographic area as defined by the zip code) by unit quantity.
5. Calculate adjustment to reimbursements to account for implementation of DMEPOS Competitive Bidding
    a. Obtain percent change ratio by dividing the difference of the re-priced payment amount and Medicare maximum payment by the Medicare maximum payment. Exclude claim if percent change ratio is greater than 100%.
    b. Apply savings ratio to covered payment amount (actual amount paid from claim.)
    c. Summarize claim payments by SSA state and county for qualified CBA claims.
    d. Multiply covered claim payments by percent change ratio to obtain Medicare savings.

	219.84	Allowed charge amount
×	0.778	Medicare share
	171.04	FFS Medicare maximum payment amount (MDCR_Max_Paid)
	18.42	Single payment amount with CPI-U for HCPCS Code A7032 in zip code 10506
×	6	unit quantity
×	0.778	Medicare share
	85.98	New Medicare Single payment amount (CBA_Bid_Amt)
	−0.497	Percent change = (CBA_Bid_Amt − MDCR_Max_Paid) / MDCR_Max_Paid
×	175.87	Covered payment amount (actual claim payment amount)
	−87.41	Change in spending

Adjusted FFS Payments based on Competitive Bid Program (CBP) for Durable Medical Equipment Prosthetic Orthotics Supplies (DMEPOS)

Section1834(a)(1)(F) of the ACA mandates adjustments to the fee schedule amounts for DMEPOS furnished on or after January 1, 2016, based on information from the Competitive Bidding Program (CBP). The adjusted fee schedule amounts were developed using the average of SPAs from the CBP to be applied in eight different regions and separated by rural and non-rural areas. Below is the process used to adjust the DMEPOS Claims in Non-CBA areas using the CBP adjusted FFS payment amounts. OACT calculates Managed Care payment amounts for CY2019 based on the 5-year average of Fee-For-Service (FFS) claims from CY2013 to CY2017. In order to reflect the new CBP adjusted DMEPOS FFS payment amounts in the base years, we use the following methodology to re-price DMEPOS claims for each year 2013 to 2017 for Non-CBP claims:

1. Download DMEPOS adjusted FFS payment amounts for Non-CBA areas including Rural and Non-Rural geographic areas and product categories from the CMS website located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html
2. Create a re-pricing table combining all DMEPOS items and geographic areas for Rural and Non-Rural Non-CBA areas.
3. Identify FFS DMEPOS payments using National Claims History (NCH) Records as loaded into Integrated Data Repository (IDR).
    a. Extract DME claim lines with claim type 72, 81 or 82.
    b. Determine whether DME claim line HCPCS code was subject to competitive bidding.
    c. Determine if DME claim was not already subject to competitive bidding based on zip code from the NCH.
    d. Include only Fee-for-Service claims.
    e. Exclude ESRD beneficiaries (beneficiary with active dialysis period at time of service.)
    f. Exclude Beneficiaries enrolled in MAO Cost Plans.
    g. Calculate Medicare maximum payment by multiplying allowed charge amount by the share to be borne by Medicare, or 77.8%.
4. Determine the re-priced payment amount based on DMEPOS Competitive Bidding by multiplying the single payment amounts (for the HCPCS code in the geographic area defined by the zip code) by unit quantity.
5. Calculate adjustment to reimbursements to account for implementation of adjusted FFS payment amounts
    a. Obtain percent change ratio by dividing the difference of the re-priced payment amount and Medicare maximum payment by the Medicare maximum payment. Exclude claim if percent change ratio is greater than 100%.
    b. Apply Percent Change ratio to covered payment amount (actual amount paid from claim.)
    c. Summarize claim payments by SSA state and county for qualified claims.
    d. Multiply covered claim payments by percent change ratio to obtain Medicare savings.

	219.84	Allowed charge amount
×	0.778	Medicare share
	171.04	FFS Medicare maximum payment amount (MDCR_Max_Paid)
	30.40	Single payment amount for HCPCS Code A7032 in zip code 10985
×	6	unit quantity
×	0.778	Medicare share
	141.91	New Medicare Single payment amount (CBA_Bid_Amt)
	−0.170	Percent change = (CBA_Bid_Amt − MDCR_Max_Paid) / MDCR_Max_Paid
×	175.87	Covered payment amount (actual claim payment amount)
	−29.90	Change in spending

Disproportionate Share (DSH)

1. Obtain FY 2019 Final Medicare DSH Supplemental Data from https://www.cms.gov/
2. NCH records
    a. Keep only inpatient claims - claim type 60
    b. Exclude ESRD beneficiaries (beneficiary with active dialysis period at time of service)
    c. Exclude Sole Community Hospitals that are projected to be paid a facility-specific rate in FY 2018 (as reflected in Supplemental DSH exhibit in FY 2019 Final IPPS rule).
    d. Exclude rehab hospitals and facilities that have tied out/terminated according to "STAR."
3. Match DSH from claim to UCP from FY 2019 Final IPPS Rule
4. Calculate adjustment factor $_{(\text{base year})}$
    a. Aggregate DSH payments $_{(\text{base year})}$ × 75 percent × FY 2019 UCP factor 2 (of 0.6751) / aggregate projected UCP $_{(\text{FY 2019})}$
        i. Note: base year represents January-September 2013
5. Calculate provider-specific per-capita UCP amount $_{(\text{base year})}$
    a. Aggregate projected UCP for provider $_{(\text{FY 2019})}$ × adjustment factor $_{(\text{base year})}$ / number of claims $_{(\text{base year})}$
6. Calculate claim level adjustment as provider-specific per-capita UCP amount $_{(\text{base year})}$ minus 75 percent of DSH included in the claim payment.
7. Below exhibit is illustration of adjustment for January-September 2013 claims.

	CY 2013 (Original)			FY 2019	CY 2013 (adjusted)	
Provider type	DSH	DSH × 75%	DSH × 75% UCP × factor 2	UCP	UCP	Repricing adjustment
DSH in 2013 and 2019	$8,022	$6,017	$4,062	$4,000	$4,000	($2,017)
$0 DSH in 2019	171	128	86	0	0	(128)
$0 DSH in 2013	0	0	0	148	148	148
Total	$8,193	$6,145	$4,148	$4,148	$4,148	($1,996)

UCP factor 2 FY 2019	0.6751

Uncompensated Care Payments (UCP)

1. Obtain FY 2018 and FY 2019 Final Medicare DSH Supplemental Data from https://www.cms.gov/
2. Records excluded from DSH Supplemental Data:
   a. Exclude Sole Community Hospitals (SCH) that are projected to be paid a facility-specific rate
   b. UCP status for FY 2019 = "SCH"
   c. UCP status for FY2018 = "SCH" and UCP status for FY2019 = "No" or missing
   d. Records with UCP status for FY2018 = "SCH" and UCP status for FY2019 = "Yes" were kept. That is, facilities that switched from SCH status to standard status.
3. National claims History (NCH) records
   a. Keep only inpatient claims - claim type 60
   b. Exclude ESRD beneficiaries (beneficiary with active dialysis period at time of service)
   c. Exclude SCH in FY 2019 (as reflected in Supplemental DSH exhibit in FY 2019 Final IPPS rule)
   d. Exclude rehab hospitals and facilities that have tied out/terminated according to "STAR"
4. Match UCP from claim to UCP from FY 2018 and FY 2019 Final IPPS Rules.
5. Providers found on the supplemental FY 2018 DSH exhibit and not found on the supplemental FY 2019 DSH exhibit and providers with FY 2019 UCP status = "N" are assigned a Factor 3 value of 0.000.
6. Calculate the gross UCP dollars for 2017 after replacing FY 2018 Factor 2 (0.5801) with FY 2019 Factor 2 (0.6751). This is the total of the re-priced UCP for this set of providers.
7. For providers with no 2017 UCP, but with inpatient claim, the re-priced UCP per claim equals the gross UCP adjustment multiplied by the FY 2018 Factor 3 divided by the number of claims.
8. Below exhibit is illustration of adjustment for calendar year 2014 claims.

		Actual 2014 UCP		FY 2019 DSH Suppl. Data		Re-priced UCP Claims	
Provider Number	**Projected to receive DSH in FY 2018**	**Dollars (000)**	**Number of claims**	**Projected to receive DSH in FY 2019**	**Factor 3**	**Gross (000)**	**Per Claim**
	YES	$8,429,416		YES	0.999999997		
	NO	$8,111		NO	0.000000000		
	n/a OR SCH	$26,277		n/a OR SCH	0.000000000		
	Subtotal	$8,463,804			0.999999997	$6,059,294	
	Factor 2		0.943		0.6751		
111111	YES	$5,952.0	8,628	YES	0.00065212	$3,951.4	$457.97
222222	YES	1,974.9	4,053	YES	0.00031123	1,885.8	465.29
333333	YES	3,091.8	5,862	YES	0.00026852	1,627.0	277.56
444444	YES	206.7	714	YES	0.00003414	206.9	289.76
555555	YES	147.9	222	YES	0.00005451	330.3	1,487.77
666666	YES	3,487.6	4,251	YES	0.00044646	2,705.2	636.38
777777	YES	2,488.0	3,404	YES	0.00034689	2,101.9	617.49
…some data not shown…							