CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1991	**Date: December 29, 2017**
	Change Request 10373

SUBJECT: Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under the Rural Community Hospital Demonstration

I. SUMMARY OF CHANGES: The Rural Community Hospital Demonstration allows up to 30 small rural hospitals that are not eligible to be designated as Critical Access Hospitals to receive payment for Medicare inpatient services under a cost-based methodology.

The demonstration was mandated for a 5-year period by section 410A of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and extended for an additional 5-year period by sections 3123 and 10313 of the Affordable Care Act. Section 15003 of the 21st Century Cures Act (Cures Act) mandates an extension for another 5-year period, whereby previously participating hospitals are allowed to continue participation, and additional hospitals are to be selected.

This memorandum provides the payment methodology for this round of the demonstration, the list of previously participating and newly selected hospitals, the periods of performance for all hospitals, previously and newly participating, the methodology for establishing enhanced interim payments for the newly participating hospitals, and requirements for the MACs with regard to collaborating with a separate audit contractor.

EFFECTIVE DATE: May 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 29, 2018

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:

One Time Notification

Attachment - One-Time Notification

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SUBJECT: Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under the Rural Community Hospital Demonstration

EFFECTIVE DATE: May 1, 2015
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I. GENERAL INFORMATION

A. Background: The Rural Community Hospital Demonstration allows up to 30 small rural hospitals that are not eligible to be designated as Critical Access Hospitals to receive payment for Medicare inpatient services under a cost-based methodology.

The demonstration was mandated for a 5-year period by section 410A of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), and extended for an additional 5-year period by sections 3123 and 10313 of the Affordable Care Act. Section 15003 of the 21st Century Cures Act (Cures Act) mandates an extension for another 5-year period, whereby previously participating hospitals are allowed to continue participation, and additional hospitals are to be selected.

Thus, participating hospitals fall into two groups: 1) those that previously participated, and are continuing into this third round of the demonstration (previously participating hospitals); and, 2) and those selected under a solicitation authorized by the Cures Act and that are beginning participation with this third round (newly participating hospitals) .

In the Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) finalized the terms of continued participation for the previously participating hospitals. For each hospital that chooses to continue participation, the demonstration cost-based methodology will apply retroactively to the end of the period authorized by the Affordable Care Act.

In order to implement this retroactive payment, CMS has communicated to the impacted Medicare Administrative Contractors (MACs) that if the cost report was closed, to reopen and issue a revised notice of provider reimbursement in accordance with the established demonstration payment methodology. For cost reports that are still open or in progress, the MACs are to adjust payment for the cost report year to accord with the demonstration payment methodology.

This memorandum provides the payment methodology for this round of the demonstration, the list of newly selected hospitals, the periods of performance for all hospitals, previously and newly participating, the methodology for establishing enhanced interim payments for the newly participating hospitals, and requirements for the MACs with regard to collaborating with a separate audit contractor.

B. Policy: 1. Payment methodology

1. CMS waives certain Medicare rules for hospitals participating in the demonstration to allow for a cost-based payment methodology for covered inpatient hospital services furnished to Medicare beneficiaries. This cost-based payment methodology is specified in accordance with section 410A of the MMA, as follows:

a) For discharges occurring in the first cost reporting period for the Agreement Period, the Participating Hospital’s payment for covered inpatient hospital services, to Medicare beneficiaries, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital will be the reasonable cost of providing

such services.

b) For discharges occurring during the second or a subsequent cost reporting period, the Participating Hospital's payment for covered inpatient hospital services to Medicare beneficiaries (**Payment**) will be the lesser of its reasonable cost or a target amount. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period as determined under 2 a) above, adjusted by the applicable percentage increase (as defined under section 1886(b)(3)(B)(i) of the Social Security Act (**the Act**)) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount increased by the applicable percentage increase for that particular cost reporting period.

All provisions of section 1886(b)(3)(B) of the Act applying to subsection d) hospitals will apply in the calculation of applicable percentage increase:

- In accordance with section 1886(b)(3)(B)(viii), if the hospital does not submit quality data as specified under the Hospital Inpatient Quality Reporting (IQR) Program, the applicable percentage increase, prior to any other reduction, will be reduced by 25 percent;
- In accordance with section 1886(b)(3)(B)(ix), subject to exceptions specified under this clause, if the hospital is not a meaningful Electronic Health Record (EHR) user (as defined in section 1886(n)(3) of the Social Security Act) the applicable percentage, prior to any other reduction, will be reduced by 50 percent for FY 2016 and 75 percent for FY 2017 and subsequent FYs;
- In accordance with section 1886(b)(3)(B)(xi), after application of sections 1886(b)(3)(B)(viii) and 1886(b)(3)(B)(ix), the applicable percentage increase shall be reduced by the productivity adjustment as described under such section, and determined by CMS;
- After adjustments in accordance with sections 1886(b)(3)(B)(viii), 1886(b)(3)(B)(ix), and 1886(b)(3)(B)(xi), in accordance with section 1886(b)(3)(B)(xii), the applicable percentage increase will be reduced by 0.2 percentage point for FY 2016 and 0.75 percentage point for FYs 2017, 2018, and 2019.
- Application of these adjustments may result in the applicable percentage increase being less than zero.
- CMS will provide updates to the determination of the applicable percentage increase in accordance with pertinent provisions of the statute, as applicable.

c) Payment for the reasonable cost of services to beneficiaries is made according to the principles stated in 42 Code of Federal Regulation (CFR) 413 and Chapter 21 of Part I of the Provider Reimbursement Manual. As stated in these documents, only costs that can directly be attributed to patient care will be included.

d) The following will be included in the determination of payment for covered inpatient hospital services for Medicare beneficiaries for any of the specified cost reporting periods:

- Swing bed services will be included;
- Capital costs will be included;
- Sixty-five percent of bad debt will be included;
- In accordance with 42 CFR 412.2(c)(5), preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the 3 calendar days immediately preceding.

e) Since the Participating Hospital will receive payment for covered inpatient hospital services for Medicare beneficiaries on the basis of a reasonable cost methodology, it will not receive add-ons associated with the Medicare inpatient prospective payment system. Therefore, the hospital will not receive the low-volume hospital payment adjustment, indirect medical education payments, or any additional payments as a Sole Community Hospital **(SCH**), Medicare Dependent Hospital (**MDH**), or Medicare Disproportionate Share

Hospital (**DSH**).

However, if there is any reason that the Participating Hospital's status as a SCH, Medicare DSH or MDH when applicable is needed for any other purpose besides Medicare inpatient payments CMS will certify that status if it continues to meet those conditions. The Participating Hospital will be able to receive payments as a SCH at the end of the agreement period, or upon voluntary termination, provided that it still meets SCH requirements.

f) According to section 3001(a) of the Affordable Care Act (ACA), the Hospital Value-Based Purchasing (HVBP) Program applies to subsection (d) hospitals, with certain exceptions. Therefore, under the Demonstration the Participating Hospital will be included in the HVBP Program, because it is a subsection (d) hospital. The HVBP Program applies to cost report periods that include discharges beginning October 1, 2012.CMS will determine exceptions for Participating Hospitals on the basis of rules specific to the HVBP Program.

In accordance with the regulations in subpart I of 42 CFR part 412 (412.160 through 412.167), the following will occur for each Participating Hospital in the Demonstration that is eligible for the HVB Program:

- CMS will calculate a value-based incentive payment adjustment factor that is to be applied to the base operating Diagnosis-Related Group (DRG) payment amount for each discharge, as if the Participating Hospital were paid for inpatient hospital services under the IPPS.This calculation will be made for each federal fiscal year.
- The MAC will calculate the value-based payment adjustment for the applicable cost report period for the Participating Hospital. (This amount is X).This amount is calculated by applying the value-based incentive payment adjustment factor for the applicable federal fiscal year to the base operating DRG payment amount for all discharges in that federal fiscal year included in the cost report year.
- 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 determined according to the cost-based payment methodology for the demonstration under items a) through e) above.This adjustment, applicable to the specific cost report period, will occur at cost report settlement.

g) Sections 3025 and 10309 of the ACA established the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to applicable hospitals with excess readmissions effective for discharges beginning October 1, 2012.The Hospital Readmissions Reduction Program applies to subsection (d) hospitals. Therefore, under the Demonstration the Participating Hospital will be included in the Hospital Readmissions Reduction Program because it is a subsection (d) hospital. In accordance with the regulations in subpart I of 42 CFR part 412 (412.152 through 412.154), the following will occur for the Participating Hospital under the Demonstration:

- CMS calculates a readmissions payment adjustment factor that is applied to the Participating Hospital's base operating DRG amount for each discharge occurring during the federal fiscal year 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 Hospital Readmissions Reduction Program.
- The MAC will calculate the amount of the readmissions payment reduction for the applicable cost report period. This amount is calculated by applying the readmissions payment adjustment factor for the applicable federal fiscal year to the operating DRG payment amount for all discharges in that federal fiscal year included in the cost report year.
- The MAC will subtract this amount (X) from the payment amount for inpatient hospital services determined according to the cost-based methodology payment methodology (under items a) through e) above) for the applicable cost report period. This subtraction will occur at cost report settlement.

h) Section 3008 of the ACA established the Hospital-Acquired Conditions Reduction Program, which, starting with discharges occurring in federal fiscal year 2015, requires a reduction of payment that would otherwise apply to applicable hospitals, determined after application of the Hospital Value-Based Purchasing and Hospital Readmissions Reduction programs.The Hospital-Acquired Conditions Program applies to subsection (d) hospitals. Therefore, under the Demonstration the Participating Hospital will be included in the Hospital-Acquired Conditions Reduction Program because it is a subsection (d) hospital. In accordance with the regulation in subpart of 42 CFR 412 part 412.172, the following will occur for each Participating Hospital in the Demonstration:

- CMS will identify the top quartile of all subsection (d) hospitals with respect to hospital-acquired conditions as measured during the applicable period. CMS will use the methodology specific to the Hospital-Acquired Conditions Reduction Program in calculating total hospital-acquired condition scores.
- If the Participating Hospital falls within the group of top quartile hospitals with respect to hospital-acquired conditions for the federal fiscal year, then the MAC will calculate one percent of the amount that would have otherwise been paid under the IPPS, following application of the Hospital Value-Based Purchasing and Hospital Readmissions Reduction programs.This resulting amount will be subtracted from the payment amount for inpatient hospital services determined according to the cost-based methodology payment methodology (under items a) through e) above) for the applicable cost report period. This subtraction will occur at cost report settlement.

2. External audits

CMS will select a separate contractor for this demonstration, who will perform detailed audits of hospitals' expenditures under the demonstration in accordance with standard principles of 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 MACs shall cooperate with the CMS contractor, providing information on interim and 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 hospitals.

3. Notice of Program Reimbursement

For each participating hospital and cost report year under the demonstration, the MAC should provide a Notice of Program Reimbursement (NPR), which, similar to previous rounds, includes a specific worksheet that identifies for both acute care and swing beds the cost amount, target amount, final payment amount, and the difference between the amounts paid under the demonstration and without the demonstration. If applicable for the hospital and specific cost report year, this worksheet should include the low-volume payment hospital adjustment amount that would have been paid absent the demonstration, and the net difference between payment under the demonstration and standard methodologies, excluding the low-volume hospital payment adjustment amount from the determination of the amount paid absent the demonstration.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility			
		A/B MAC	D M E	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10373.1	Hospitals participating in the current round of the demonstration and their participation dates are identified in Appendix 1. The MACs shall use this Appendix to identify both previously and newly participating hospitals.	X								CMS
10373.2	For each of these hospitals, effective for cost reports beginning in accordance with the participation date stated in Appendix 1, the MAC shall make payment for inpatient services and ONLY inpatient services as the reasonable cost of providing the services, in accordance with the principles stipulated under Policy.	X								
10373.3	The MAC shall continue to pay for acute care services on a claim-by-claim basis according to the standard IPPS methodology. The cost-based payment under the demonstration shall not interfere with the claims system.	X								
10373.4	The MAC shall continue to pay for swing-bed services on a claim-by-claim methodology according to the standard SNF PPS methodology. The cost-based payment under the demonstration shall not interfere with the claims system.	X								
10373.5	For each participating hospital, the MAC shall adjust interim payments for acute care and swing bed services separately, to reflect the reasonable cost of providing these services.	X								
10373.5.1	CMS has communicated to the MACs to calculate the bi-weekly interim payment to the previously participating hospitals for the cost report year currently in progress. For each of these hospitals, the MAC shall calculate and administer such a bi-weekly interim payment for the subsequent cost report years.	X								CMS
10373.5.2	For the newly participating hospitals, the MAC shall calculate and administer such a bi-weekly interim payment for the cost report years identified in Appendix A, i.e., cost report years starting on or after October 1, 2017.	X								
10373.5.3	For acute care services, the MAC shall calculate the variance between the IPPS and reasonable cost methods, and adjust the interim payments for each hospital. This adjustment should be made in the form of a bi-weekly level payment, based on a per discharge calculation as for periodic interim payments.	X								
10373.5.4	The MAC should target this adjustment to interim	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	payments across the cost report period so as to approximate the amount to be paid under cost-based reimbursement for the cost reporting period for acute care services.									
10373.5.5	For swing-bed services, the MAC shall calculate the variance between Skilled Nursing Facilty (SNF) PPS and reasonable cost methods, making bi-weekly level payments as described above for the acute care services.	X								
10373.5.6	The MAC should target this adjustment to interim payments across the cost report period so as to approximate the amount to be paid under cost-based reimbursement for the cost reporting period for swing-bed services.	X								
10373.6	For each participating hospital, the MAC shall finalize the settlement of the first cost reporting period according to the Participation Period identified in Appendix 1.	X								
10373.6.1	For cost reports that are finalized according to previous CMS communications, this settlement shall proceed in accordance with the existing payment methodology.	X								
10373.6.2	For cost reports that are pending, the cost report settlement should proceed under the Policy outlined in this CR.	X								
10373.7	The MAC shall provide all needed information, including interim payments, lump sum payments, interim and finalized cost reports, and supporting materials to the audit contractor selected by CMS to perform a more detailed audit of expenditures under the demonstration in accordance with standard principles of cost-based reimbursement.	X								CMS
10373.8	The MAC shall include the determinations of this audit contractor into the cost-based payments made under the demonstration to the participating hospitals.	X								
10373.9	For each hospital, for each year subsequent to the first year of the Participation Period, the MAC shall apply the target amount methodology in accordance with the Policy of this CR. This methodology will apply	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	separately for acute care and swing-bed payments.									
10373.9.1	The MAC should define discharges for both acute care and swing beds to include all patient codes.	X								
10373.9.2	The MAC shall calculate a target amount for acute care services for the second cost report year of the Participation Period for each hospital according to the following formula: 1. Calculate a ratio from first year cost report data of the cost of acute care services per discharge; 2. Multiply this amount by the number of acute care discharges on the second year cost report; 3. Multiply by the appropriate year'(s) applicable percentage increase, as specified by section 1886(b)(3)(B)(i) of the Social Security Act.	X								
10373.9.3	If the amount of reasonable costs for acute care services in Year 2 is less than the target amount, then payment by the MAC shall be the reasonable cost amount.	X								
10373.9.4	If the target amount is less than the amount of reasonable costs for acute care services for Year 2, then the payment by the MAC for acute care services for Year 2 shall be the target amount.	X								
10373.9.5	This methodology should be conducted for Years 3 through 5, each year updating the target amount for acute care services by the appropriate number(s) for the applicable percentage increase, specific to the Federal Fiscal Year(s).	X								
10373.9.6	The MAC shall calculate a target amount for swing bed services for the second cost report year of the Participation Period for each hospital according to the following formula: 1. Calculate a ratio from first year cost report data of the cost of swing bed services per discharge; 2. Multiply this amount by the number of swing bed discharges on the second year cost report. 3. Multiply by the appropriate year'(s) applicable	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	percentage increase, as specified by section 1886(b)(3)(B)(i) of the Social Security Act.									
10373.9.7	If the amount of reasonable costs for swing bed services in Year 2 is less than the target amount, then payment by the MAC shall be the reasonable cost amount.	X								
10373.9.8	If the target amount is less than the amount of reasonable costs for swing bed services for Year 2, then the payment by the MAC for swing bed services for Year 2 shall be the target amount.	X								
10373.9.9	This methodology should be conducted for Years 3 through 5, each year updating the target amount for swing bed services by the appropriate number(s) for the applicable percentage increase, specific to the Federal Fiscal Year(s).	X								
10373.9.10	The applicable percentage increase should be based on the methodology defined by CMS for the specific Federal Fiscal Year(s).	X								
10373.10	In conducting final settlement, the MAC shall calculate and apply payment adjustments specific to the Hospital Value-Based Purchasing Program in accordance with the principles outlined under Policy.	X								
10373.11	In conducting final settlement, the MAC shall calculate and apply payment adjustments specific to the Hospital Readmissions Reduction Program in accordance with the principles outlined under Policy.	X								
10373.12	In conducting final settlement, the MAC shall calculate and apply payment adjustments specific to the Hospital-Acquired Conditions Reduction Program in accordance with the principles outlined under Policy.	X								
10373.13	The MAC shall provide interim and finalized cost reports, lump sum adjustments and other supporting materials to the audit contractor selected by CMS to perform a detailed audit of cost-based expenditures under the demonstration.	X								
10373.14	The MAC shall include the determinations of the audit	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contractor selected by CMS regarding cost amounts into the cost-based payments made to the hospitals participating in the demonstration.									
10373.15	For each cost reporting period, the MAC shall collect necessary data from each hospital for the provider-specific file in order to collect disproportionate share percentages, Sole Community Hospital adjustments, and, if applicable, low-volume hospital payment and Medicare Dependent Hospital adjustments when applicable.	X								
10373.16	The date of discharge shall determine into what cost reporting period a claim falls.	X								
10373.17	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								
10373.18	Hospitals shall be able to terminate participation at any time during the Participation Period.	X								
10373.19	For each participating hospital and cost report year under the demonstration, the MAC shall shall provide a Notice of Program Reimbursement (NPR), which, similar to previous rounds, includes a specific worksheet that identifies for both acute care and swing beds the cost amount, target amount, final payment amount, and the difference between the amounts paid under the demonstration and without the demonstration. If applicable for the hospital and specific cost report year, this worksheet should include the low-volume hospital payment adjustment amount that would have been paid absent the demonstration, and the net difference between payment under the demonstration and standard methodologies, excluding the low-volume hospital payment adjustment amount from the determination of the amount paid absent 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:
	N/A

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: 1

Appendix 1: Rural Community Hospital Demonstration

Participating Hospitals and Periods of Participation for Cures Act Extension (Round 3)

	Hospital Name	FYE	Participation Period	Base Period
	Round I Hospitals – Previously Participating			
1	Central Peninsula Hospital – 20024; Soldatna, AK	6/30	7/1/2015 – 6/30/2020	7/1/2015 – 6/30/2016
2	Bartlett Regional Hospital – 20008; Juneau, AK	6/30	7/1/2015 – 6/30/2020	7/1/2015 – 6/30/2016
3	Brookings Health Center – 430008; Brookings, SD	12/31	10/1/2015- 9/30/2020	10/1/2015 – 9/30/2016
4	Columbus Community Hospital - 280111; Columbus, NE	4/30	5/1/2015 - 4/30/2020	5/1/2015 – 4/30/2016
	Round 2 Hospitals – Previously Participating			
5	Delta County Memorial Hospital – 60071; Delta, CO	12/31	1/1/2017 -12/31/2021	1/1/2017 – 12/31/2017
6	Yampa Valley Medical Center – 60049; Steamboat Springs, CO	9/30	10/1/2016 -9/30/2021	10/1/2016 – 9/30/2017
7	St. Anthony Regional Hospital – 160005; Carroll, IA	6/30	7/1/2016 – 6/30/2021	7/1/2016 – 6/30/2017
8	Grinnell Regional Medical Center – 160147; Grinnell, IA	12/31	1/1/2017 – 12/31/2021	1/1/2017 – 12/31/2017
9	Skiff Medical Center – 160032; Newton, IA	6/30	7/1/2016 – 6/30/2021	7/1/2016 - 6/30/2017
10	Lakes Regional Healthcare -160124; Spirit Lake, IA	6/30	7/1/2016 – 6/30/2021	7/1/2016 – 6/30/2017
11	Mercy Hospital – Fort Scott - 170058; Fort Scott, KS	6/30	7/1/2016 – 6/30/2021	7/1/2016 – 6/30/2017
12	Geary Community Hospital – 170074; Junction City, KS	4/30	5/1/2016 – 4/30/2021	5/1/2016 – 4/30/2017
13	Bob Wilson Memorial Hospital - 170110; Ulyssees, KS	12/31	1/1/2017 -12/31/2021	1/1/2017 – 12/31/2017
14	Inland Hospital -200041; Waterville, ME	9/30	10/1/2016 – 9/30/2021	10/1/2016 – 9/30/2017
15	Maine Coast Memorial Hospital - 200050; Ellsworth, ME	9/30	10/1/2016 – 9/30/2021	10/1/2016 – 9/30/2017
16	Marion General Hospital -250085; Columbia, MS	9/30	10/1/2016 – 9/30/2021	10/1/2016 – 9/30/2017
17	Alta Vista Regional Hospital - 320003; Las Vegas, NM	8/31	9/1/2016 – 8/31/2021	9/1/2016 – 8/31/2017
	Round 3 Hospitals – Newly Participating			

18	Montrose Memorial Hospital – 06006; Montrose, CO	12/31	1/1/2018 -12/31/2022	1/1/2018 – 12/31/2018
19	Trinity Regional Medical Center – 160016; Fort Dodge, IA	12/31	1/1/2018 -12/31/2022	1/1/2018 – 12/31/2018
20	St. John's Medical Center – 530015; Jackson, WY	6/30	7/1/2018 – 6/30/2023	7/1/2018 – 6/30/2019
21	Valley View Hospital -060075; Glenwood Springs, CO	12/31	1/1/2018 - 12/31/2022	1/1/2018 – 12/31/2018
22	Great Plains Regional Medical Center – 370019; Elk City, OK	6/30	7/1/2018 – 6/30/2023	7/1/2018 – 6/30/2019
23	Aroostook Medical Center – 200018; Presque Isle, ME	9/24	10/1/2017 – 9/30/2022	10/1/2017 – 9/30/2018
24	Anderson Regional Medical Center - South -250081; Meridian, MS	9/30	10/1/2017 – 9/30/2022	10/1/2017 – 9/30/2018
25	McPherson Hospital -170105; McPherson, KS	6/30	7/1/2018 – 6/30/2023	7/1/2018 – 6/30/2019
26	Avera St. Luke's Hospital -430014; Aberdeen, SD	6/30	7/1/2018 – 6/30/2023	7/1/2018 – 6/30/2019
27	Highland Community Hospital - 250117; Picayune, MS	9/30	10/1/2017 – 9/30/2022	10/1/2017 – 9/30/2018
28	Morton County Health System - 170166; Elkhart, KS	12/31	1/1/2018 – 12/31/2022	1/1/2018 – 12/31/2018
29	St. Anthony Summit Medical Center -060118; Frisco, CO	6/30	7/1/2018 – 6/30/2023	7/1/2018 – 6/30/2019
30	Avera Queen of Peace – 430013; Mitchell, SD	6/30	7/1/2018 – 6/30/2023	7/1/2018 – 6/30/2019