CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 77	**Date: July 22, 2011**
	Change Request 7505

SUBJECT: Method of Cost Settlement for inpatient Services for Rural Hospitals Participating Under Demonstrations Authorized by Section 410A of the Medicare Modernization Act. Sections 3123 and 10313 of the Affordable Care Act authorized an expansion of the demonstration and an extension for additional 5-year period. This CR gives instructions for this additional 5-year period. This CR is an extension of CR 5020 for additional 5-year period.

I. SUMMARY OF CHANGES: This demonstration reimburses specific hospitals for Medicare inpatient services through cost based reimbursement. Eight hospitals are continuing from the initial 5-year demonstration period, mandated by section 410A of the Medicare Modernization Act. Eighteen new hospitals will be starting the demo starting with cost report periods beginning May 1, 2011 through January 1, 2012. This CR identifies the hospitals, MACs and legacy contractors, and defines the payment methodology.

EFFECTIVE DATE: January 1, 2010
IMPLEMENTATION DATE: August 22, 2011

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):
Funding for implementation activities will be provided to contractors through the regular budget process.

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

Attachment – One-Time Notification

Pub. 100-	Transmittal: 77	Date: July 22, 2011	Change Request: 7505

SUBJECT: 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 authorized an expansion of the demonstration and an extension for an additional 5-year period. This CR gives instructions for this additional 5-year period. This CR is an extension of CR 5020 for this additional 5-year period.

Effective Date: January 1, 2010
Implementation Date: August 22, 2011

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. As of November 2010, out of 18 hospitals chosen between 2004 and 2008, 8 hospitals were still participating in the demonstration. Holy Cross Hospital in Taos, NM is withdrawing effective its cost report end – May 31, 2011. Its participation in the continuation period will be effective for the cost report year June 1, 2010 – May 31, 2011.

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 project – with a 5-year continuation period for each hospital. Holy Cross Hospital in Taos, NM is withdrawing effective its cost report end – May 31, 2011. Its participation in the continuation period will be effective for the cost report year June 1, 2010 – May 31, 2011.

In addition, 18 new hospitals will begin the demonstration. Each will participate for a period of 5 years, beginning on its first cost report start date on or after April 1, 2011. The period of performance will conclude December 31, 2016.

B. Policy: For each chosen hospital:

1. In the first cost reporting period (the first cost reporting period starting in CY 2010 for continuing hospitals, the first cost reporting period on or after April 1, 2011 for newly participating hospitals) -- the hospital's payment for covered inpatient services, 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. Swing bed services are included among the covered services for which the hospital receives payment on the basis of reasonable costs.

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

3. One hundred percent of bad debt will be included in the determination of reasonable cost.

4. Capital costs will be included in the determination of reasonable cost.

5. Costs of outpatient services performed within 72 hours prior to inpatient admission will be bundled, as appropriate, as part of the cost of the inpatient service.

6. The reasonable cost payment for the first cost reporting period applies to the first cost reporting period starting in CY 2010 for the 8 hospitals continuing from the initial demonstration period. It applies to the first cost reporting period on or after April 1, 2011 for the 18 newly participating hospitals.

7. In subsequent cost reporting periods of the demonstration program, payment for covered inpatient services is the lesser of reasonable costs of providing such services or the target amount. This methodology applies to all 26 participating hospitals.

8. The payment methodology for covered inpatient services during subsequent cost reporting periods, i.e., Years 2 through 5, is described in Attachment A.

9. If a hospital offers swing bed services, the fiscal intermediary will calculate two separate target amounts for the purpose of calculating reimbursement:

    - for acute care services; and
    - for swing-bed services.

10. If a hospital provides only acute care services, then there will be only one target amount – for acute care services.

11. Hospitals participating in the demonstration will be able to participate in other CMS demonstrations.

12. Hospitals participating in the demonstration will not be able to receive the low volume payment adjustment in addition.

13. The MAC or fiscal intermediary will not make any Medicare disproportionate share payment in addition to the cost-based payment for inpatient services. For each cost reporting period, the MAC or fiscal intermediary shall collect necessary data from each hospital for the provider specific file in order to calculate disproportionate share percentages. The fiscal intermediary will not make any payment for Medicare disproportionate share in addition to the cost-based payment for inpatient services. The purpose of this data collection is that hospitals will use these percentages to potentially be eligible for non-Medicare benefit programs tied to the disproportionate share percentage or status.

14. Under the demonstration, a hospital will also not receive add-on payments as a Sole Community Hospital or Medicare Dependent Hospital.
15. If in either FY 2011 or FY 2012 a participating hospital receives an additional payment for qualifying hospitals with lowest enrollee Medicare spending – under section 1109 of the Affordable Care Act – the MAC or FI will subtract the amount paid under this provision from the cost-based payment for Medicare inpatient services calculated under this demonstration methodology. This deduction will be made only if the additional payment being made to the hospital under section 1109 occurs at a point in time concurrent with the hospital's period of performance in the demonstration.

For example: if payment under section 1109 occurs in September 2011, and –

a) A hospital is one of the originally participating hospitals, beginning the extension period with cost report period starting January 1, 2010, then the amount received under section 1109 will be subtracted from the demonstration payment for the cost report year January 1, 2011 – December 31, 2011.
b) A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year July 1, 2011-June 30, 2012, then the amount received under section 1109 will be subtracted from the demonstration payment for that cost report year.
c) A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year January 1, 2012- December 30, 2012, then the amount of the payment for FY 2011 will not be subtracted for the hospital.

These additional payments will be made by CMS to specific hospitals through a separate contractor. The CMS project officer for the Rural Community Hospital Demonstration will notify the respective MAC or FI of the payment amounts to the relevant hospitals under section 1109.

The following hospitals are participating in the demonstration and that will also be receiving additional payments under section 1109:

Originally Participating Hospitals -	Holy Cross Hospital	Taos, NM	320013
	Columbus Community Hospital	Columbus, NE	280111
	Brookings Hospital	Brookings, SD	430008
	Garfield Memorial Hospital	Panguitch, UT	460033
Newly Selected Hospitals -	Yampa Valley Medical Center	Steamboat Springs, CO	60049
	St Anthony Regional Hospital	Carroll, IA	160005
	Skiff Medical Center	Newton, IA	160032
	Lakes Regional Healthcare	Spirit Lake, IA	160124
	Grinnell Regional Medical Center	Grinnell, IA	160147
	Geary Community Hospital	Junction City, KS	170074
	Miles Memorial Hospital	Damariscotta, ME	200002
	Inland Hospital	Waterville, ME	200041
	San Miguel Hospital Corporation	Las Vegas, NM	320003
	Cibola General Hospital	Grants, NM	320037

16. Since hospitals participating in the demonstration are considered to be subsection (d) hospitals, they will be able to participate in the Medicare HIT incentive payment program. They will be required to follow the regulations as subsection (d) hospitals.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B MA	DME MA	FI	CARRIE	RHHI	Shared-System Maintainers	OTHER

		C	C		R		FISS	MCS	VMS	CWF	
7505.1	"Continuing hospitals" are identified in Table A. These are the 8 hospitals that were selected for the demonstration between 2004 and 2008 and that were still participating effective as of May 1, 2011.										CMS-Innovation Center
7505.2	"Newly participating hospitals" are identified in Table B. These are the 18 hospitals that were selected for participation in 2010.										CMS Innovation Center
7505.3	For each of the 8 continuing hospitals, effective for cost reports beginning on or after 1/1/10, the AB/MAC and/or FIs shall make the payment for inpatient services and ONLY inpatient services as the reasonable cost of providing the services.	X		X							
7505.4	For each of the 18 newly participating hospitals, effective for cost reports beginning on or after 4/1/11, the AB/MAC and/or FI shall make payment for inpatient services and ONLY inpatient services as the reasonable cost of providing the services.	X		X							
7505.5	For each participating hospital, i.e., a demonstration hospital identified in Table A or B, effective for the cost reporting periods identified in 7505.3 or 7505.4, the AB/MAC and/or FI shall adjust interim payments for acute care services to reflect the reasonable cost of providing these services.	X		X							
7505.5.1	Using the latest finalized or tentatively settled cost report, whichever is from the later period, the AB/MAC or FI shall determine what payments the hospital would have under the IPPS method and also under a reasonable cost method.	X		X							
7505.5.2	The FI shall calculate the variance between the IPPS and reasonable cost methods, and adjust the interim payments for the 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 payment (PIP) providers	X		X							
7505.5.3	The FI should target this adjustment to interim payments across the cost report period for each hospital so as to approximate the amount to be paid under cost-based reimbursement for the cost reporting period.	X		X							
7505.5.4	Participating hospitals with certified swing-beds will also receive cost-based reimbursement for swing-bed services.	X		X							
7505.5	The FI shall continue to pay swing-bed services under the SNF PPS method on a claim-by-claim basis. The FI shall calculate the variance between SNF PPS and reasonable cost methods, making bi-weekly level payments as described above for the hospital acute care	X		X							

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	
	services.										
7505.6	For each of the identified hospitals, the respective MAC or FI shall conduct an audit of the first cost report in the extension period. For hospitals in Table A, this will be for the first cost report period beginning on or after January 1, 2010. For hospitals in Table B, it will be for the first cost report period beginning on or after April 1, 2011.	X		X							
7505.6.1	The FI shall reimburse the hospitals for the reasonable cost of services to beneficiaries according to principles stated in 42 CFR 413 and Chapter 21 of Part I of the Provider Reimbursement Manual. As stated in these documents, only costs that can be directly attributed to patient care will be reimbursed.	X		X							
7505.7	As appropriate, the MAC or FI shall bundle the costs of outpatient services performed within 72 hours prior to the inpatient admission as part of the cost of the inpatient service.	X		X							
7505.8	From the audit for each hospital in Table A and B, the respective MAC or FI will determine an amount for the reasonable costs for providing acute care services in the first cost report year.	X		X							
7505.9	From each hospital in Table A and B that provides swing bed services, the MAC or FI will determine an amount for the reasonable costs for providing swing bed services in the first cost report year.	X		X							
7505.10	For each hospital in Table A and B, the MAC or FI shall add the amount of the reasonable costs for the hospital for acute care and swing beds to arrive at an amount of the total reasonable costs for the hospital.	X		X							
7505.11	For each hospital in Table A and B, the FI shall compare the amount of total reasonable costs for the hospital to the amount paid in interim payments for the cost report period.	X		X							
7505.11.1	If the amount of interim payments is greater, then the hospital shall pay the difference to the MAC or FI	X		X							
7505.11.2	At any time, the FI may change the amount of interim payments, depending on its calculation of the hospital's	X		X							

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	
	reasonable costs.										
7505.12	For each hospital in both Table A and B, after the cost report for the second year is submitted, the MAC or FI shall conduct an audit of reasonable cost according to the same principles as 7505.6 and 7505.6.1	X		X							
7505.13	From the audit for each hospital in both Table A and B, the respective MAC or FI shall determine an amount for the reasonable costs of providing acute care services in the second cost report year.	X		X							
7505.14	The MAC or FI shall define discharges for both acute care and swing beds to include all patient codes.	X		X							
7505.15	The respective MAC or FI shall calculate a target amount for acute care services for the second cost report year for each hospital in both Table A and B according to the following formula: a. Calculate a ratio from first year cost report data of the cost of acute care services per discharge; b. Divide by case-mix index for Year 1; c. Multiply this amount by the number of acute care discharges on the second year cost report; d. Multiply by the case-mix index for Year 2 acute care services. e. Multiply by the acute care prospective payment update factor.	X		X							Hospital
7505.16	If the amount of reasonable costs for acute care services is less than the target amount, then the MAC or FI payment for acute care services for Year 2 is the reasonable cost amount.	X		X							
7505.17	If the target amount is less than the amount of reasonable costs for Year 2, then the payment by MAC or FI for acute care services for Year 2 is the target amount.	X		X							
7505.18	The MAC or FI shall conduct a settlement between the second year payment amount and interim payments paid out in the second cost report year according to the same	X		X							

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	
	principles in 7505.11 and 7505.11.1.										
7505.19	There will be no case-mix adjustment for swing bed payments.	X		X							Hospital
7505.20	The MAC or FI shall 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. The MAC or FI will only make this deduction if the additional payment being made to the hospital under section 1109 occurs at a point in time concurrent with the hospital's period of performance in the demonstration. . These additional payments will be made by CMS to specific hospitals through a separate contractor. The CMS project officer for the Rural Community Hospital Demonstration will convey the payment amounts for the relevant hospitals to the respective MAC or FI. The following hospitals are participating in the demonstration and that will also be receiving additional payments under section 1109: Originally Participating Hospitals – Holy Cross Hospital Taos, NM 320013 Columbus Community Hospital Columbus, NE 280111 Brookings Hospital Brookings, SD 430008 Garfield Memorial Hospital Panguitch, UT 460033 Newly Selected Hospitals -	X		X							CMS Innovation Center

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	
	Yampa Valley Medical Center Steamboat Springs, 60049 CO St Anthony Regional Hospital Carroll, IA 160005 Skiff Medical Center Newton, IA 160032 Lakes Regional Healthcare Spirit Lake, IA 160124 Grinnell Regional Medical Center Grinnell, IA 160147 Geary Community Hospital Junction City, KS 170074 Miles Memorial Hospital Damariscotta, ME 200002 Inland Hospital Waterville, ME 200041 San Miguel Hospital Corporation Las Vegas, NM 320003 Cibola General Hospital Grants, NM 320037										
7505.21	For each cost reporting period, the MAC or FI shall collect necessary data from each hospital for the provider-specific file in order to be able to report disproportionate share percentages	X		X							Hospital
7505. 22	For the purposes of payment under this demonstration, acute care services shall be defined as those billed by the hospital with a type of bill code '11X". Swing-bed services shall be defined as those billed with the type of bill code '18'.	X		X							Hospital
7505.23	The date of discharge shall determine into what cost reporting period a claim falls.	X		X							Hospital
7505.24	Claims that overlap cost reporting periods shall not be split. The MAC or FI shall assign them to the cost reporting period for the date of discharge.	X		X							
7505.25	Hospitals shall be able to terminate participation prior to the official end of the demonstration, effective at the	X		X							Hospital

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	
	beginning of the cost report period.										

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	
7505.26	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 site 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 your 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		X							CMS Innovation Center

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
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:

V. CONTACTS

Pre-Implementation Contact(s): Sid Mazumdar, (410) 786-6673

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

VI. FUNDING

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

Funding for implementation activities will be provided to contractors through the regular budget process.

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.

TABLE A - Eight Originally Participating Hospitals					
Hospital Name	City, State	Jurisdiction	Contractor	Cost Report Start Date	Base Period for Audit
Central Peninsula Hospital - 20024	Soldotna, AK	J-2	Noridian (legacy)	7/1	7/1/10 – 6/30/11
Bartlett Regional Hospital - 20008	Juneau, AK	J-2	Noridian (legacy)	7/1	7/1/10- 6/30/11
Columbus Community Hospital - 280111	Columbus, NE	J-5	WPS	5/1	5/1/10- 4/30/11
Banner Churchill Community Hospital – 290006	Fallon, NV	J-1	WPS (legacy)	1/1	1/1/10 – 12/31/10
Holy Cross Hospital – 320013	Taos, NM	J-4	Trail-blazer	6/1	6/1/10 – 5/31/11
Garfield Memorial Hospital - 460033	Panguitch, UT	J-3	Noridian	1/1	1/1/10- 12/31/10
Mt. Edgecumbe Hospital - 20027	Sitka, AK	J-4 (IHS)	Trail-blazer	10/1	10/1/10- 9/30/11
Brookings Health Center –430008	Brookings, SD	J-3	Noridian	1/1	1/1/11- 12/31/12

TABLE B - 18 Newly Participating Hospitals					
Delta County Memorial Hospital -60071	Delta, CO	J-4	Trailblazer	1/1	1/1/12-12/31/12
Yampa Valley Medical Center - 60049	Steamboat Springs, CO	J-4	Trailblazer	10/1	10//1/11-9/30/12
Sterling Regional Medical Center - 60076	Sterling, CO		WPS legacy	1/1	1/1/12-12/31/12
St. Anthony Regional Hospital -160005	Carroll, IA	J-5	WPS	7/1	7/1/11-6/30/12
Grinnell Regional Medical Center - 160147	Grinnell, IA	J-5	WPS	1/1	1/1/12-12/31/12
Skiff Medical Center- 160032	Newton, IA	J-5	WPS	7/1	7/1/11-6/30/12
Lakes Regional Healthcare - 160124	Spirit Lake, IA	J-5	WPS	7/1	7/1/11-6/30/12
Mercy Hospital - 170058	Fort Scott, KS	J-5	WPS	7/1	7/1/11-6/30/12
Mercy Hospital - 170010	Independence, KS	J-5	WPS	7/1	7/1/11-6/30/12
Geary Community Hospital - 170074	Junction City, KS	J-5	WPS	5/1	5/1/11-4/30/12
Bob Wilson Memorial Hospital - 170110	Ulysses, KS	J-5	WPS	7/1	1/1/12-12/31/12
Miles Memorial Hospital -200002	Damariscotta, ME	J-14	NHIC	10/1	10/1/11-9/30/12

Franklin Memorial Hospital -200037	Farmington, ME	J-14	NHIC	7/1	7/1/11-6/30/12
Inland Hospital-200041	Waterville, ME	J-14	NHIC	9/28	9/28/11-9/26/12
Maine Coast Memorial Hospital -200050	Ellsworth, ME	J-14	NHIC	7/1	7/1/11-6/30/12
Marion General Hospital -250085	Columbia, MS	J-7	Pinnacle	10/1	10/1/11-9/30/12
Cibola General Hospital – 320037	Grants, NM	J-4	Trailblazer	7/1	7/1/11-6/30/12
San Miguel Hospital Corporation 320003	Las Vegas, NM		WPS Legacy	9/1	9/1//11-8/31/12

Attachment A – Payment Methodology for Years 2 through 5

A) The payment methodology for inpatient services for Years 2 through 5 applies to both the hospitals that are continuing from the original period and the newly selected hospitals. For the 7 continuing hospitals (Holy Cross Hospital in Taos, NM withdrew effective June 1, 2011), the second cost report years follow upon the hospitals' first extension years beginning January 1, 2010. For the 18 newly selected hospitals, the second cost report years follow after the first cost report years beginning April 1, 2011. For years 2 through 5, payment for each year is the lesser of reasonable costs or the target amount.

B) The amounts of reasonable cost for Year 1 and subsequent years acute care and swing bed services will be determined as distinct values. These values will be used to determine the target amounts for acute care and swing bed services, respectively, for Year 2.

C) To calculate the base-year target amount per-discharge for the hospital's acute care services:

a) In the first cost reporting period of the demonstration, the hospital's acute care target amount is calculated according to the following steps.

i) Calculate the costs per discharge by dividing the total cost of acute care services by the total number of acute care discharges. Discharges are defined to include all patient status codes.

ii) Divide this amount by the case mix index of the hospital's acute care patients.

b) The base-year target amount per-discharge will be updated in year 2 through 5 by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act) in the market basket percentage increase for each particular cost reporting period.

c) To calculate the target amount limitation for Years 2 through 5, the update target amount per-discharge will be multiplied by:

i) the case-mix index of the hospital's acute care patients for the particular cost reporting period;

ii) the hospital's Medicare acute care discharges for the particular cost reporting period.

D) There will be no case-mix adjustment for swing bed services for hospital cost reporting periods beginning January 1, 2010 and after.

E) To calculate the base-year target amount per-discharge of the swing-bed services:

a) In the first cost reporting period of the demonstration, the swing-bed target amount is calculated according to the following steps:

i) Calculate an amount per swing bed discharge by dividing the total costs of swing bed services by the total number of swing bed discharges. Discharges are defined to include all patient status codes

ii) The base-year target amount per-discharges will be updated in years 2 through 5 by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act) in the market basket percentage increase for each particular cost reporting period.

iii) To calculate the target amount limitation for Years 2 through 5, the updated target per-discharge will be multiplied by the number of Medicare swing-bed discharges for the particular cost reporting period.

F) For the calculation of the acute care target amount, if the case-mix adjustment declines from the previous to the later year, the corresponding factor used in the payment methodology will also decline. It is possible that payment for acute care will decline for the hospital.

i) The case-mix adjustment is determined by calculating 1 + the percent variance between the base year case-index and the current year case-mix index. For example, a base year case-mix of 1.25 and a current year case-mix index of 1.5 results in a variance of .25 and a percent variance of .20. The case-mix adjustment is1 + the difference between current and base year case mix divided by the base year case mix = 1 + [(1.5 -1.25)/1.25] = 1.20.

ii) If a provider's current year case-mix is less than in the base year, the target amount will be adjusted downward. For example, if the case-mix in the base year is 1.5 and in the current year it is 1.25, the case-mix adjustment = 1 + [(1.25 – 1.5)/1/5] =.8333.

G) Each hospital currently participating will be able to participating for 5 consecutive cost reporting periods.

H) For each hospital, the respective MAC or fiscal intermediary will conduct an audit of the hospital's cost report and settlements in accordance with Chapter 8 of the CMS Publication #100-06, "Medicare Financial Management Manual." In each settlement, the MAC or fiscal intermediary will make a calculation of the reasonable cost of the hospital's acute care and swing bed services for the respective cost reporting period. The calculation of reasonable cost amounts will be made separately for acute care and swing bed services. The MAC or FI will compare this amount to the amount of interim payments made to the hospital during that period. From this calculation, the MAC or fiscal intermediary will determine whether Medicare owes the hospital money or vice versa.