CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11243	**Date: January 27, 2022**
	Change Request 12590

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

I. SUMMARY OF CHANGES: This memorandum provides the payment methodology for Round 4 of the demonstration, the list of participating hospitals, the periods of performance for all hospitals, the methodology for establishing enhanced interim payments and conducting final cost report settlements, and requirements for the MACs with regard to collaborating with a separate audit contractor.

EFFECTIVE DATE: May 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 29, 2022

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

Pub. 100-20	Transmittal: 11243	Date: January 27, 2022	Change Request: 12590

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

EFFECTIVE DATE: May 1, 2020
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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) mandated an extension for another 5-year period, whereby previously participating hospitals were allowed to continue participation, and additional hospitals were selected.

Section 128 of the Consolidated Appropriations Act of 2021 extended the demonstration for another 5-year period. No new hospitals were selected under this re-authorization

Thus, participating hospitals fall into three groups, as identified in Appendix 1, according to round when each hospital began participation in the demonstration:

- Round 1 Hospitals (4): The new participation period for these 4 hospitals extends retroactively to 2020.
- Round 2 Hospitals (10): These ten hospitals were scheduled to end participation during 2021; however, their participation will continue without any break in payment with a new 5-year period of participation.
- Round 3 Hospitals (12): The original period of participation for these 12 hospitals is scheduled to end during 2022 and 2023. Each of these hospitals will be eligible for a new 5-year period upon the completion of its scheduled end date.

This memorandum provides the payment methodology for the new round of the demonstration authorized by the Consolidated Appropriations Act of 2021, the list of participating hospitals, and their periods of participation. This memorandum also describes the requirements for the MACs as to collaborating with a separate audit contractor.

B. Policy:

1. Payment methodology

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:

1. 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 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 1 a) above, adjusted by the applicable percentage increase (as defined under section 1886(b)(3)(B)(i) of the Social Security 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.

c. CMS is clarifying that in determining the target amount for the second and subsequent cost reporting periods, the reasonable cost amount in the base year will be multiplied by the ratio of the hospital's acute care case mix index for the current year to that of the base year.

CMS will determine the target amount as follows:

• Calculate the ratio from the first-year cost report of the cost of acute care services per discharge;

• Divide this amount by the acute care case-mix index for Year 1;

• Multiply this amount by the number of acute care discharges in the current year cost report;

• Multiply by the acute care case-mix index for the current year;

• Multiply by the applicable percentage increase for each year subsequent to Year 1.

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 points 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.

d. Payment 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 directly be attributed to patient care will be included.

e. 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:

1. Swing bed services will be included;
2. Capital costs will be included;
3. Sixty-five percent of bad debt will be included;
4. 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.
5. The Participating Hospital will receive payment on a reasonable cost-based payment for anesthesia services provided in the hospital by qualified non-physician anesthetists employed by the hospital subject to the stipulations in 42 CFR 412.113(c).

f. Since the Participating Hospital will receive payment for covered inpatient hospital services for Medicare beneficiaries based on 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.

g. According to section 3001(a) of the 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 based on 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 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 Medicare Administrative Contractor (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 f) above. This adjustment, applicable to the specific cost report period, will occur at cost report settlement.

h. 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 f) above) for the applicable cost report period. This subtraction will occur at cost report settlement.

i. 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 f) 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 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			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12590.1	CMS will notify the MACs of the hospitals participating in the current round of the demonstration and their participation dates. Appendix 1 identifies all hospitals participating in the demonstration, in addition to the dates of their participation. The respectiive participation rounds are determined according to the date when the hospital initiated participation.									CMS
12590.2	For each of these hospitals, effective for cost reports beginning in accordance with the participation date stated in Appendix 1, the A/B MAC part A 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								
12590.3	For each participating hospital, the A/B MAC Part A shall adjust interim payments for acute care and swing bed services separately, to reflect the reasonable cost of providing these services.	X								
12590.3.1	The A/B MAC Part A 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								
12590.3.2	The A/B MAC Part A 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	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	with the claims system.									
12590.4	CMS has communicated to the A/B MAC Part A 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 A/B MAC Part A shall calculate and administer such a bi-weekly interim payment for the subsequent cost report years.	X								
12590.4.1	For acute care services, the A/B MAC Part A shall determine what payments the hospital would receive under the IPPS and also under the reasonable cost method.	X								
12590.4.2	The A/B MAC Part A 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								
12590.4.3	The A/B MAC Part A shall 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.	X								
12590.4.4	For swing-bed services, the A/B MAC Part A shall determine what payments the hospital would receive under the SNF PPS and also under the reasonable cost method.	X								
12590.4.5	The A/B MAC Part A shall calculate the variance between SNF PPS and reasonable cost methods, making bi-weekly level payments as described above for the acute care services.	X								
12590.4.6	The A/B MAC Part A 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.	X								
12590.5	For each participating hospital, the A/B MAC Part A shall finalize the settlement of the base year cost reporting period identified in Appendix 1.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12590.5.1	The A/B MAC Part A 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								
12590.5.2	The A/B MAC Part A shall include the determinations of this audit contractor into the cost-based payments made under the demonstration to the participating hospitals.	X								
12590.6	For each hospital, for each year subsequent to the base 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 separately for acute care and swing-bed payments.	X								
12590.6.1	The A/B MAC Part A shall define discharges for both care and swing beds to include all patient codes.	X								
12590.6.2	The A/B MAC Part A 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. Divide this amount by the acute care case-mix index for Year 1 1. Multiply this amount by the number of acute care discharges on the second year cost report; 2. Multiply by the acute care case-mix index for Year 2 1. Multiply by the appropriate year'(s) applicable percentage increase, as specified by section 1886(b)(3)(B)(i) of the Social Security Act.	X								
12590.6.3	If the amount of reasonable costs for acute care services in Year 2 is less than the target amount, then payment by the A/B MAC Part A shall be the	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	reasonable cost amount.									
12590.6.4	If the target amount is less than the amount of reasonable costs for Year 2, then the payment by the A/B MAC Part A for acute care services for Year 2 is the target amount.	X								
12590.6.5	The A/B MAC Part A shall implement this methodology for Years 3 through 5, each year updating the acute care case-mix index for the current year and incorporating the appropriate numbers for the applicable percentage increase specific to the Federal Fiscal Year(s).	X								
12590.6.6	The A/B MAC Part A 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 percentage increase, as specified by section 1886(b)(3)(B)(i) of the Social Security Act.	X								
12590.6.7	If the amount of reasonable costs for swing bed services in Year 2 is less than the target amount, then payment by the A/B MAC Part A shall be the reasonable cost amount.	X								
12590.6.8	If the target amount is less than the amount of reasonable costs for Year 2, then the payment by the A/B MAC Part A for acute care services for Year 2 is the target amount.	X								
12590.6.9	The A/B MAC Part A shall conduct this methodology 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								
12590.6.10	The applicable percentage increase should be based on the methodology defined by CMS for the specific	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Federal Fiscal Year(s).									
12590.7	In conducting final settlement, the A/B MAC Part A shall calculate and apply payment adjustments specific to the Hospital Value-Based Purchasing Program in accordance with the principles outlined under Policy.	X								
12590.8	In conducting final settlement, the A/B MAC Part A shall calculate and apply payment adjustments specific to the Hospital Readmissions Reduction Program in accordance with the principles outlined under Policy.	X								
12590.9	In conducting final settlement, the A/B MAC Part A shall calculate and apply payment adjustments specific to the Hospital-Acquired Conditions Reduction Program in accordance with the principles outlined under Policy.	X								
12590.10	For each cost reporting period, the A/B MAC Part A 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								
12590.11	For each participating hospital and cost report year under the demonstration, the A/B MAC Part A shall should provide a Notice of Program Reimbursement (NPR), which 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								
12590.12	The date of discharge shall determine into what cost reporting period a claim falls.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12590.13	Claims that overlap cost reporting periods shall not be split. The A/B MAC Part A shall assign them to the cost reporting period for the date of discharge.	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: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Siddhartha Mazumdar, 410-982-8150 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: Participation Periods for Round 4 Change Request

Hospital Name	Period of Participation under 21st Century Cures Act	Period of Participation under Consolidated Appropriations Act	Base Year/Years 2 - 5	MAC
Round 1				
Central Peninsula Hospital 020024 Soldotna, AK	7/1/2015 – 6/30/2020	7/1/2020 – 6/30/2025	Base: 7/1/2020 – 6/30/2021 Y2-Y5: 7/1/2021 – 6/30/2025	Noridian
Bartlett Regional Hospital 020008 Juneau, AK	7/1/2015 – 6/30/2020	7/1/2020-- 6/30/2025	Base: 7/1/2020 – 6/30/2021 Y2-Y5: 7/1/2021 – 6/30/2025	Noridian
Brookings Health Center 430008 Brookings, SD	10/1/2015 – 9/30/2020	10/1/2020 – 9/30/2025	Base: 1/1/2021 – 12/31/2021 Y2-Y5: 1/1/2022 – 9/30/2025	Noridian
Columbus Community Hospital 280111 Columbus, NE	5/1/2015 – 4/30/2020	5/1/2020 – 4/30/2025	Base: 5/1/2020 – 4/30/2021 Y2-Y5: 5/1/2021 – 4/30/2025	WPS
Round 2				
St. Anthony's Regional Medical Center 160005 Carroll, IA	7/1/2016 – 6/30/2021	7/1/2021 – 6/30/2026	Base: 7/1/2021 – 6/30/2022 Y2-Y5: 7/1/2022 – 6/30/2026	WPS

MercyOne Newton Medical Center 160032 Newton, IA	7/1/2016 – 6/30/2021	7/1/2021 – 6/30/2026	Base: 7/1/2021 – 6/30/2022 Y2-Y5: 7/1/2022-6/30/2026	WPS
Lakes Regional Healthcare 160124 Spirit Lake, IA	7/1/2016 – 6/30/2021	7/1/2021 – 6/30/2026	Base: 7/1/2021 – 6/30/2022 Y2-Y5: 7/1/2022 – 6/30/2026	WPS
UnityPoint Grinnell Regional Medical Center – 160147 Grinnell, IA	1/1/2017 – 12/31/2021	1/1/2022 – 12/31/2026	Base: 1/1/2022 – 12/31/2022 Y2-Y5: 1/1/2023 – 12/31/2026	WPS
Geary Community Hospital 170074 Junction City, KS	5/1/2016 – 4/30/2021	5/1/2021 – 4/30/2026	Base: 5/1/2021 -4/30/2022 Y2-Y5: 5/1/2022 – 4/30/2026	WPS
Bob Wilson Memorial Grant County Hospital – 170110 Ulysses, KS	1/1/2017- 12/31/2021	1/1/2022 – 12/31/2026	Base: 7/1/2022 – 6/30/2023 Y2-Y5: 7/1/2023 – 12/31/2026	WPS
UCHealth Yampa Valley Medical Center -- 060049 Steamboat Springs, CO	10/1/2016 – 9/30/2021	7/1/2021 – 6/30/2026	Base: 7/1/2021 – 6/30/2022 Y2-Y5: 7/1/2022 – 6/30/2026	Novitas
Delta Health—060071 Delta, CO	1/1/2017 – 12/31/2021	1/1/2022 – 12/31/2026	Base: 1/1/2022 – 12/31/2022 Y2-Y5: 1/1/2023 – 12/31/2026	Novitas
Marion General Hospital 250085 Columbia, MS	10/1/2016 – 9/30/2021	10/1/2021 – 9/30/2026	Base: 10/1/2021 – 9/30/2022 Y2-Y5: 10/1/2022 – 9/30/2026	Novitas
Northern Light Maine Coast Hospital 200050 Ellsworth, ME	10/1/2016 – 9/30/2021	10/1/2021 – 9/30/2026	Base: 10/1/2021 – 9/30/2022	NGS

			Y2-Y5: 10/1/2022 – 9/30/2026	
Round 3				
Montrose Memorial Hospital 060006 Montrose,CO	1/1/2018 – 12/31/2022	1/1/2023 – 12/31/2027	Round 3 Base: 1/1/2018 – 12/31/2018 Y2-Y5: 1/1/2019 – 12/31/2022 Round 4 Base: 1/1/2023 – 12/31/2023 Y2-Y5: 1/1/2024 – 12/31/2027	Montrose, Valley View – Novitas; Morton, Trinity - WPS
Morton County Health System 170166 Elkhart,KS	1/1/2018 – 12/31/2022	1/1/2023 - 12/31/2027		
Trinity Regional Medical Center 160016 Fort Dodge, IA	1/1/2018 – 12/31/2022	1/1/2023 – 12/31/2027		
Valley View Hospital 060075 Glenwood Springs, CO	1/1/2018 – 12/31/2022	1/1/2023 – 12/31/2027		
Avera St. Luke's 430014 Aberdeen, SD	7/1/2018 -6/30/2023	7/1/2023 – 6/30/2028	Round 3 Base: 7/1/2018 – 6/30/2019 Y2-Y5: 7/1/2019 – 6/30/2023 Round 4 Base: 7/1/2023 – 6/30/2024 Y2-Y5: 7/1/2024 – 6/30/2028	Avera St. Luke's and Queen of Peace, St. John's – Noridian; St. Anthony Summit, Great Plains -- Novitas
Avera Queen of Peace 430013 Mitchell, SD	7/1/2018 – 6/30/2023	7/1/2023 – 6/30/2028		
St. John's Medical Center 530015 Jackson, WY	7/1/2018 – 6/30/2023	7/1/2023 – 6/30/2028		
St. Anthony Summit Medical Center 060118 Frisco, CO	7/1/2018 – 6/30/2023	7/1/2023 – 6/30/2028		
Great Plains Regional Medical Center 370019	7/1/2018 – 6/30/2023	7/1/2023 – 6/30/2028		
Highland Community Hospital 250117 Picayune, MS	10/1/2017 – 9/30/2022	10/1/2022 -9/30/2027	Round 3 Base: 10/1/2017 - 9/30/2018 Y2-Y5: 10/1/2018 – 9/30/2022 Round 4	Highland – Novitas; Anderson – WPS; Aroostook -- NGS
Anderson Regional Medical Center – South – 250081 Meridian, MS	10/1/2017 – 9/30/2022	10/1/2022 – 9/30/2027		

The Aroostook Medical Center 200018 Presque Isle, ME	10/1/2017 – 9/30/2022	10/1/2022 – 9/30/2027	Base: 10/1/2022 – 9/30/2023 Y2-Y5: 10/1/2023 – 9/30/2027	