2552-10 T-5
Cost Report Update

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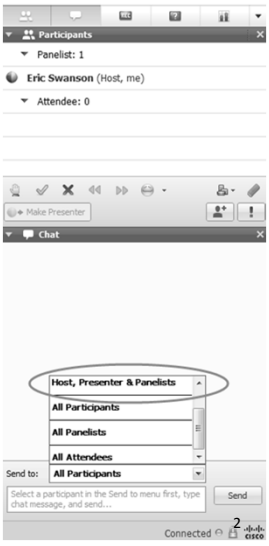
Questions?

- Use WebEx “Chat” feature
- Post WebEx email to:
  eric@hfssoft.com



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Objectives

- 2552-10 T-5
  - General Information
  - Background
  - Form Changes
  - HFS System Changes
  - Data/PS&R Requirements
  - New Edits
- 2552-10 T-6?
- Questions

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General

- Published on CMS website 3/28/2014
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R5P240.html?DLPage=1&DLFilter=cost&DLSort=0&DLSortDir=ascending
- HFS test case submitted 3/28/2014
- Software approved (TBD)
- Software distributed (Scheduled 4/4/2014)
- Initial 2552-10 T-5 software version will be designated 5.0.153.2

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General

- Effective Date – "Cost Reporting Periods Overlapping or Beginning on or After October 1, 2013."
  - Model 4 bundled payments for care improvement (BPCI) initiative but paid outside of the bundled payment in accordance with ACA 2010, section 3023
  - Update of the low income patient (LIP) adjustment factor and update of the teaching adjustment factor
  - Include Medicare labor and delivery days in the calculation of the Medicare patient load ratio used to apportion direct graduate medical education payments in accordance with the Federal Fiscal Year (FFY) 2014 IPPS final rule
  - **Implement calculation of Uncompensated Care Payments**
- Minor provisions effective earlier
  - Corrected instructions for lines 71 and 72, medical supplies charged to patients and implantable devices charged to patients, respectively.
  - Added line 39.98 to reflect partial or full credits received from manufacturers for replaced devices.

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Model 4 Bundled Payments

- Model 4 bundled payments for care improvement (BPCI) initiative
  - 15 Providers in demonstration
  - Bundled payment for
    - Acute care hospital stay and Part B during stay
    - Readmission within 30 days and Part B
    - Payment does not include IME, DSH, Outlier, Capital
      - Similar to MC+ simulated DRG payments to compute IME/DSH
      - Outlier/Capital settled on cost report
- Additional Information Available at:
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8070.pdf

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IRF Updates

- IRF payment factors updated for services on or after 10/1/2013
  - LIP adjustment factor from 0.4613 to 0.3177
  - Teaching adjustment factor from 0.6876 to 1.0163
- Additional Information Available at:
  - FR, Vol. 78, No. 151, dated August 6, 2013, page 47869
  - http://www.gpo.gov/fdsys/pkg/FR-2013-08-06/pdf/2013-18770.pdf

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Medicare Labor and Delivery Days

- FFY 2013 Final Rule Included labor and delivery room days in DSH/IME calculation
  - Did not impact DGME or cost-based
- FFY 2014 Final Rule
  - Incorporates labor and delivery room days into DGME
  - Will not impact cost-based including para-medical
  - Effective for cost reporting periods BEGINNING on or after 10/1/2013
- Additional Information Available at:
  - FR, Vol. 78, No. 160, dated August 19, 2013, page 50729
  - http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

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DSH/Payments for Uncompensated Care

- Effective for services on or after 10/1/2013
- Two payments
  - "Empirically Justified" DSH amount
    - Effectively 25% of previous DSH payment
  - Payment for "uncompensated care"
    - "Pool" based on 75% of what would have been paid adjusted for changes in uninsured population
    - Allocate pool based on "the aggregate amount of uncompensated care for all subsection (d) hospitals"
      - Use SSI and Medicaid ratios similar to DSH

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DSH/Payments for Uncompensated Care

- 25% - Empirically Justified DSH amount
  - For Discharges on or after 10/1/2013
    - 25% of what otherwise would have been paid
      - 12% cap where applicable
      - "Pickle" provisions

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DSH/Payments for Uncompensated Care

- Additional payment for "uncompensated care payment"
  - 75% of what would have been paid
    - Adjusted for change in percentage of uninsured
    - Allocate pool based on "the aggregate amount of uncompensated care for all subsection (d) hospitals"
      - » Pre-calculated payment to provider for FY 2014
        - Medicaid days from 2010/2011 cost reports
        - FFY 2011 SSI days
      - » Payment will be made on per-discharge basis (proposed as bi-weekly)
    - Reconciliation only for:
      - » Providers determined to not be eligible
      - » Estimated per-discharge/actual number of discharges

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DSH/Payment for Uncompensated Care

- Additional Information Available at:
  - Medicare DSH Table
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Data-Files.html?DLPage=1&DLSort=0&DLSortDir=ascending
- FR, Vol. 78, No. 160, dated August 19, 2013, page 50729
  - http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

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Cost Report Changes – Model 4

4090 (Cont.) FORM CMS-2552-10 DRAFT

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	WORKSHEET E, PART A

Check applicable box: [ ] Hospital

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG amounts other than outlier payments		1
1.01	*DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)*		*1.01*
1.02	*DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)*		*1.02*
1.03	*DRG for federal specific operating payment for Model 4 BPCI (see instructions)*		*1.03*
2	Outlier payments for discharges (see instructions)		2
2.01	Outlier reconciliation amount		2.01
2.02	*Outlier payment for discharges for Model 4 BPCI (see instructions)*		*2.02*
3	Managed care simulated payments		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)		4

Worksheet E, Part A - Added lines 1.03 and 2.02
- 1.03 for DRG payments. Only for IME and DSH calculation, will not be added to settlement.
- 2.02 for Outlier payments. Will be added to settlement as additional payment outside bundled payment.

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Cost Report Changes – Model 4

4090 (Cont.) FORM CMS-2552-10 DRAFT

CALCULATION OF CAPITAL PAYMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET L

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX [ ] Hospital [ ] Subprovider (other) [ ] PPS [ ] Cost Method

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	*Model 4 BPCI Capital DRG other than outlier*		*1.01*
2	Capital DRG outlier payments		2
2.01	*Model 4 BPCI Capital DRG outlier payments*		*2.01*
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment *(multiply line 5 by the sum of lines 1 and 1.01)*		6
7	Percentage of SSI recipient patient days to Medicare Part A patient		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (line 10 *times the sum of* lines 1		11
12	Total prospective capital payments (sum of lines 1, *1.01*, 2, *2.01*, 6		12

Worksheet L - Added lines 1.01 and 2.01
- 1.01 for Capital DRG payments. Will be used for IME and DSH capital calculation, and will be added to settlement as additional payment outside bundled payment.
- 2.01 for Outlier payments. Will be added to settlement as additional payment outside bundled payment.

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Cost Report Changes – LIP

02-14 FORM CMS-2552-10 4090 (Con

CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS	PROVIDER CCN: 14-0635 COMPONENT NO 14-T635	PERIOD: FROM 01/01/2013 TO 12/31/2013	WORKSHEET E-3, PART III

PART III - MEDICARE PART A SERVICES - IRF PPS

[ ] Hospital
[x] Subprovider

		1	1.01	
1	Net Federal PPS Payment (see instructions)			
2	Medicare SSI ratio (IRF PPS only) (see instructions)			
3	Inpatient Rehabilitation LIP Payments (see instructions)			
4	Outlier Payments			
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending			
5.01	C			5
6	N			
7	C			
8	C			
9	Ir			
10	Average Daily Census (see instructions)			
11	Teaching Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1 *(see instructions)*			
12	Teaching Adjustment (line 1 multiplied by line 11) *(see instructions)*			
13	Total PPS Payment *(see instructions)*			

Worksheet E-3, Part III – Subscript column 1 for pre/post 10/1/2013 services.
- Line 1 - Net Federal PPS Payments, PS&R split 10/1/2013.
- Line 3 – LIP calculation using pre/post 10/1 factor.
- Lines 11 and 12 – Teaching adjustment using pre/post 10/1/2013 factor.

HFS PS&R reconciliation will assign payments if 10/1 split requested

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Cost Report Changes – Labor Room Days

DRAFT FORM CMS-2552-10 4090 (Cont.)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA — WORKSHEET S-3 PART I

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips: Title V	Title XVIII	Title XIX	Total All Patients	Discharges: Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)											1
29	Ambulance Trips											29
30	Employee discount days (see instructions)											30
31	Employee discount days -IRF											31
32	Labor & delivery (see instructions)											32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)											32.01
33	LTCH non-covered days											33

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Worksheet S-3 – Line 32, Columns 2 and 3
- Line 32, columns 2 and 3 actually opened in T-4 for FFY 2013 DSH/IME changes.
- Line 36, column 6 opened for Medicare LDR days in T-5 for cost reporting periods beginning on or after 10/1/2013.
- For cost reporting periods beginning on or after 10/1/2013 the FFY 2013 change will apply to E-4 DGME calculation, as well as the DSH/IME.

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Cost Report Changes – Labor Room Days

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET E-4

Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days *(see instructions)*				26
27	Total inpatient days (see instructions)				27
28	Ratio of inpatient days to total inpatient days				28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare *Advantage*				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36

Worksheet E-4 – Lines 26 and 27
- Instructional change including LDR into program patient load.
- For cost reporting periods beginning on or after 10/1/2013.

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Cost Report Changes – Labor Room Days

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | PROVIDER CCN: | PERIOD: FROM _____ TO | WORKSHEET E-4

Check applicable box:

Line Descriptions

Line 26--*Effective for cost reporting periods beginning prior to October 1, 2013, e*nter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable. *Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable plus line 32.* For titles V or XIX, enter the amounts from columns 5 or 7, respectively, sum of lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable *plus column 7, line 32 for title XIX.*

For title XVIII, enter in column 2, Medicare managed care days from Worksheet S-3, Part I, column 6, lines 2, 3 and 4. For title XIX, enter in column 2, Medicaid managed care days from Worksheet S-3, Part I, column 7, lines 2, 3 and 4.

Line 27--*Effective for cost reporting periods beginning prior to October 1, 2013, t*ransfer to columns 1 and 2, respectively, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts, as applicable.

Effective for cost reporting periods beginning on or after October 1, 2013, transfer to columns 1 and 2, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts, as applicable, plus line 32.

Worksheet E-4 – Lines 26 and 27
- Instructional change including LDR into program patient load.
- For cost reporting periods beginning on or after 10/1/2013.

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Cost Report Changes – Uncompensated Care

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 PART I TO _____

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O. Box:				1
2	City:	State:	Zip Code:	County:		2

	Inpatient PPS Information	1	2	
22	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR §412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.			22
22.01	*Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)*			22.01
23				23

Worksheet S-2 – Lines 22.01

- For cost reports straddling 10/1/2013
  - Column 1 will always be "N"
  - Column 2 reflects determination made in FFY 2014 IPPS Final Rule
- For cost reporting periods beginning 10/1/2013
  - Column 1 reflects determination made in FFY 2014 IPPS Final Rule
- For non-10/1 cost reporting periods beginning after 10/1/2013
  - Columns 1 and 2 will reflect data for 2 FFY end

Data for FFY 2014 available at CMS website

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Data-Files.html?DLPage=1&DLSort=0&DLSortDir=ascending

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Cost Report Changes – Uncompensated Care

FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act- Medicare DSH-Supplemental Data

Updated September 30, 2013 to reflect changes in Correction Notice and Interim Final Rule with Comment

PROV	Name	Medicaid Days	SSI Days	Insured Low Income Days	Factor 3	Total Uncompensated Care Payment Amount	Claims Average	Estimated Per Claim Amount	Projected to Receive DSH for FY 2014
010001	SOUTHEAST A	16388	5700	22088	0.000606318	$5,484,980.30	7872	$696.77	Y
010005	MARSHALL ME	4234	1221	5455	0.000149740	$1,354,607.37	2744	$493.60	Y
010006	ELIZA COFFEE	8383	2843	11226	0.000308155	$2,787,685.12	5210	$535.10	Y
010007	MIZELL MEMO	773	370	1143	0.000031375	$283,834.32	980	$289.53	Y
								$666.18	Y
								$821.20	Y
								$528.81	Y
								$741.59	Y
								A	N
								$642.58	Y
								$707.57	Y
								$262.78	Y
010023	BAPTIST MEDI	25883	3635	29518	0.000810272	$7,330,027.55	5303	$1,382.15	Y
010024	JACKSON HOS	11227	4559	15786	0.000433327	$3,920,042.51	5113	$766.73	Y

CMS Table can be used to confirm Worksheet S-2, Line 22.01

- Table posted on CMS website.
- HFS to provide edits and will lookup table values.
- If provider number not in table, provider considered "new."

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Cost Report Changes – Uncompensated Care

4090 (Cont.) CMS FORM-2552-10 02-14

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: 14-0635 COMPONENT CCN:	WORKSHEET E, PART A

Check Applicable Box	[x] Hospital [ ] Subprovider (other)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG Amounts Other than Outlier Payments	-	1
1.01	*DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)*	4,682,094	1.01
1.02	*DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)*	1,560,698	1.02
1.03	*DRG for Federal specific operating payment for Model 4 BPCI (see instructions)*	725,000	1.03
			2
			2.01
			2.02
			3
			4
			30
			31
			32
33	Allowable disproportionate share percentage (see instructions)	0.2109	33
34	Disproportionate share adjustment (see instructions)	1,107,967	34

Step one – Reduce "Empirically Justified" DSH to 25%
- For cost reporting periods straddling 10/1/2013
  - Line 1.01 – DRG pre 10/1/2013 (for full DSH calculation)
  - Line 1.02 – DRG post 10/1/2013 (for 25% DSH calculation)
- Cost reporting periods beginning on or after 10/1/2013 will once again use line 1.
- Line 34 – Will calculate DSH applying reduction to post 10/1/2013 DRG payments.

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Cost Report Changes – Uncompensated Care

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: 14-0635 COMPONENT CCN:		WORKSHEET E, PART A

Check Applicable Box	[x] Hospital [ ] Subprovider (other)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	*Total uncompensated care amount available for payment (factor 1 x factor 2)*	-	-	35
35.01	*Factor 3 (see instructions)*			35.01
35.02	*Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)*	-	2,173,632	35.02
35.03	*Pro rata share of the hospital uncompensated care payment amount (see instructions)*		547,875	35.03
36	*Total uncompensated care (sum of columns 1 and 2 on line 35.03)*		547,875	36

Step 2 – Reconcile Uncompensated Care pool adjustment
- Three options
  - Hospital paid on interim basis
  - Hospital in table but was not paid on interim basis
  - Hospital not in Table (new)
- Reconciliation on E, Part A, lines 35 - 36

IF WORKSHEET S-2, LINE 22 IS "N" (provider did not qualify for traditional DSH) LINES 35 – 36 WILL NOT BE COMPLETED.

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Cost Report Changes – Uncompensated Care

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: 14-0635 COMPONENT CCN:		WORKSHEET E, PART A
Check Applicable Box	[x] Hospital [ ] Subprovider (other)		

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	*Total uncompensated care amount available for payment (factor 1 x factor 2)*	-	-	35
35.01	*Factor 3 (see instructions)*			35.01
35.02	*Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)*	-	2,173,632	35.02
35.03	*Pro rata share of the hospital uncompensated care payment amount (see instructions)*		547,875	35.03
36	*Total uncompensated care (sum of columns 1 and 2 on line 35.03)*		547,875	36

Option One – Hospital paid on interim basis (S-2, line 22.01, "Y")
- Only lines 35.02 and 35.03 completed
  - Line 35.02 from CMS table
  - Line 35.02 will be edited/populated from table if not input
  - Line 35.03 computed
  - Cost reporting periods straddling 10/1/2013 – only column 2 completed
  - Cost reporting periods beginning after 10/1/2013 may include 2 FFYs

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Cost Report Changes – Uncompensated Care

	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	*Total uncompensated care amount available for payment (factor 1 x factor 2)*	-	-	35
35.01	*Factor 3 (see instructions)*			35
35.02	*Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)*	-	1,354,607	35
35.03	*Pro rata share of the hospital uncompensated care payment amount (see instructions)*		341435	35
36	*Total uncompensated care (sum of columns 1 and 2 on line 35.03)*		341435	36

FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act- Medicare DSH-Supplemental Data

Updated September 30, 2013 to reflect changes in Correction Notice and Interim Final Rule with Comment

PROV	Name	Medicaid Days	SSI Days	Insured Low Income Days	Factor 3	Total Uncompensated Care Payment Amount	Claims Average	Estimated Per Claim Amount	Projected to Receive DSH for FY 2014
010001	SOUTHEAST A	16388	5700	22088	0.000606318	$5,484,980.30	7872	$696.77	Y
010005	MARSHALL ME	4234	1221	5455	0.000149740	$1,354,607.37	2744	$493.60	Y
010006	ELIZA COFFEE	8383	2843	11226	0.000308155	$2,787,685.12	5210	$535.10	Y
010007	MIZELL MEMO	773	370	1143	0.000031375	$283,834.32	980	$289.53	Y

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Cost Report Changes – Uncompensated Care

	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	Total uncompensated care amount available for payment (factor 1 x factor 2)	-	9,046,380,143	35
35.01	Factor 3 (see instructions)		0.000000576	35
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)	-	5,215	35
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,314	35
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,314	36

Option Two – Hospital NOT paid on interim basis (S-2, line 22.01, "N") but was included in CMS table.

- Lines 35 - 35.03 completed
  - Line 35 – For FFY 2014 the total pool amount is a fixed $9,046,380,143
  - Line 35.01 – Factor 3, from CMS table.
  - Line 35.02 – Computed as line 35 times 35.01. This amount will be -0- if the provider did not qualify for traditional DSH (S-2, line 22, is "N").
  - Line 35.03 computed using days in cost reporting period falling within FFY to total days in FFY.
  - Cost reporting periods straddling 10/1/2013 – only column 2 completed.
  - Cost reporting periods beginning after 10/1/2013 may include 2 FFYs.

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Cost Report Changes – Uncompensated Care

	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	Total uncompensated care amount available for payment (factor 1 x factor 2)	-	9,046,380,143	35
35.01	Factor 3 (see instructions)		0.000000576	35
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)	-	5,215	35
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,314	35
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,314	36

FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act- Medicare DSH-Supplemental Data

Updated September 30, 2013 to reflect changes in Correction Notice and Interim Final Rule with Comment

PROV	Name	Medicaid Days	SSI Days	Insured Low Income Days	Factor 3	Total Uncompensated Care Payment Amount	Claims Average	Estimated Per Claim Amount	Projected to Receive DSH for FY 2014
010001	SOUTHEAST A	16388	5700	22088	0.000606318	$5,484,980.30	7872	$696.77	Y
010016	SHELBY BAPTI	8134	1962	10096	0.000277136	$2,507,079.01	3381	$741.59	Y
010018	CALLAHAN EY	12	9	21	0.000000576	N/A	N/A	N/A	N
010019	HELEN KELLER	6305	1276	7581	0.000208099	$1,882,544.17	2930	$642.58	Y
010021	DALE MEDICA	1479	791	2270	0.000062312	$563,695.46	797	$707.57	Y
010022	CHEROKEE ME	326	201	527	0.000014466	$130,866.74	498	$262.78	Y
010023	BAPTIST MEDI	25883	3635	29518	0.000810272	$7,330,027.55	5303	$1,382.15	Y

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Cost Report Changes – Uncompensated Care

	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	Total uncompensated care amount available for payment (factor 1 x factor 2)	-	9,046,380,143	35
35.01	Factor 3 (see instructions)		0.000014570	35
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)	-	2,173,632	35
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		547,875	35

Option Three – Hospital NOT paid on interim basis and NOT in CMS table (New)

- Lines 35 - 35.03 completed
  - Line 35 – For FFY 2014 the total pool amount is a fixed $9,046,380,143
  - Line 35.01 – Needs to be computed and input (using Medicaid and SSI days from applicable FFY)
  - Line 35.02 – Computed as line 35 times 35.01. This amount will be -0- if the provider did not qualify for traditional DSH (S-2, line 22, is "N")
  - Line 35.03 computed using days in cost reporting period falling within FFY to total days in FFY
  - Cost reporting periods straddling 10/1/2013 – only column 2 completed
  - Cost reporting periods beginning after 10/1/2013 may include 2 FFYs

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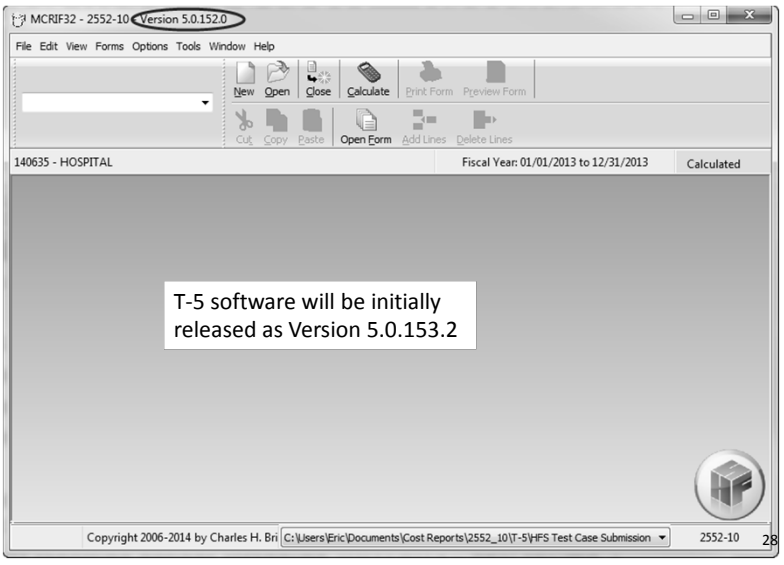
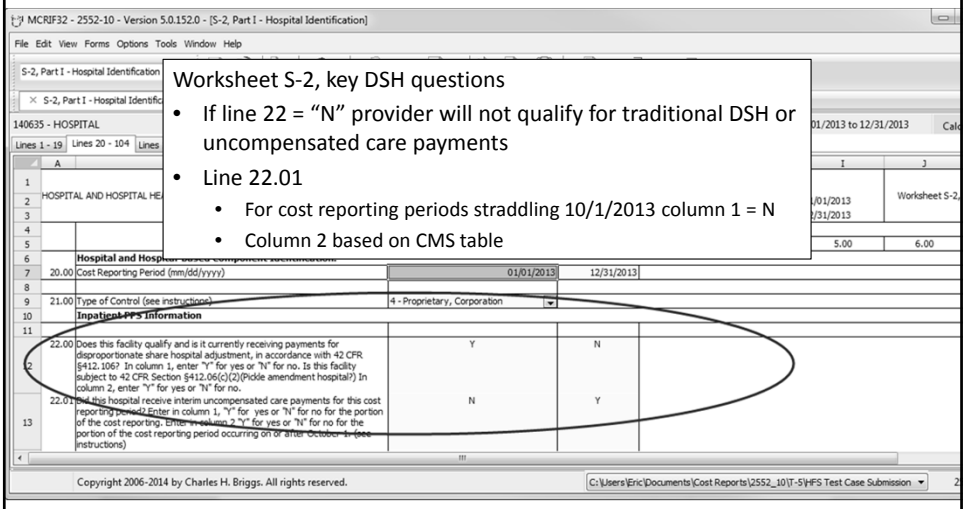
HFS System Changes



T-5 software will be initially released as Version 5.0.153.2

28

HFS System Changes



Worksheet S-2, key DSH questions

- If line 22 = "N" provider will not qualify for traditional DSH or uncompensated care payments
- Line 22.01
  - For cost reporting periods straddling 10/1/2013 column 1 = N
  - Column 2 based on CMS table

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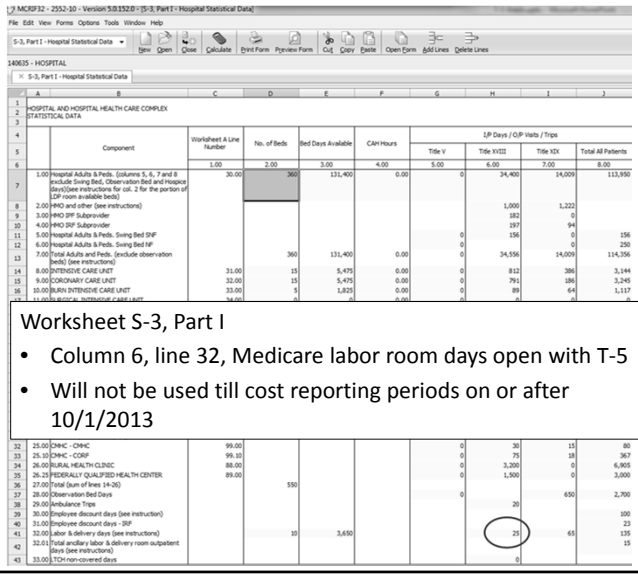
HFS System Changes



Worksheet S-3, Part I

- Column 6, line 32, Medicare labor room days open with T-5
- Will not be used till cost reporting periods on or after 10/1/2013

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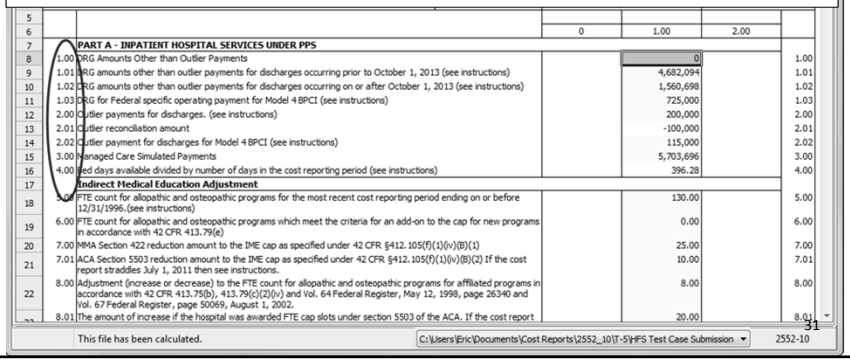
HFS System Changes

Worksheet E, Part A

- For cost reporting periods straddling 10/1/2013
  - PS&R Split at 10/1/2013
  - Pre – DRG amounts on line 1.01
  - Post – DRG amounts on line 1.02
- Cost reporting periods beginning on or after 10/1/2013 return to use of line 1.
- Model 4 BPCI payments on lines 1.03 and 2.02 (From PS&R)



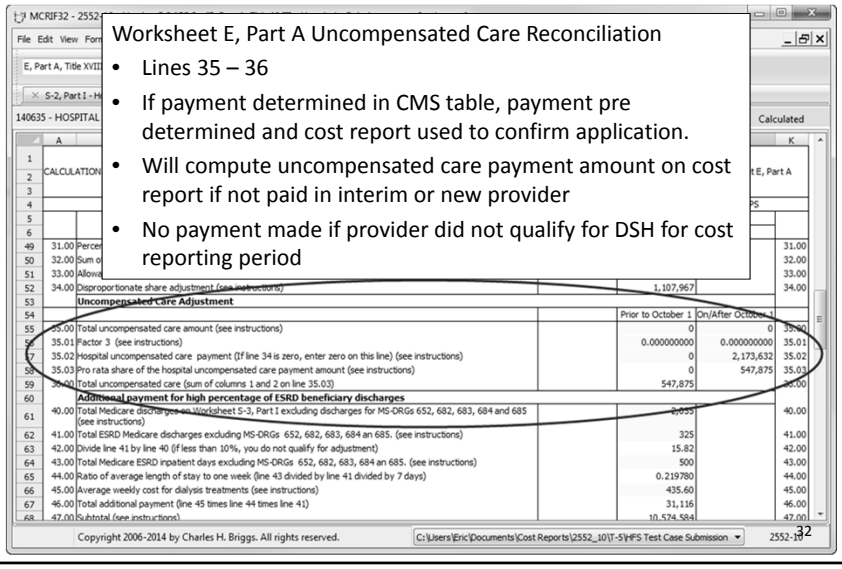
			0	1.00	2.00	
7		**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**				
8	1.00	DRG Amounts Other than Outlier Payments		0		1.00
9	1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		4,682,094		1.01
10	1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,560,698		1.02
11	1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		725,000		1.03
12	2.00	Outlier payments for discharges. (see instructions)		200,000		2.00
13	2.01	Outlier reconciliation amount		-100,000		2.01
14	2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		115,000		2.02
15	3.00	Managed Care Simulated Payments		5,703,696		3.00
16	4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		396.28		4.00
17		**Indirect Medical Education Adjustment**				
18	5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		130.00		5.00
19	6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
20	7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		25.00		7.00
21	7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		10.00		7.01
22	8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		8.00		8.00
	8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		20.00		8.01

This file has been calculated. C:\Users\Eric\Documents\Cost Reports\2552_10\T-5\HFS Test Case Submission 2552-10

HFS System Changes

Worksheet E, Part A Uncompensated Care Reconciliation

- Lines 35 – 36
- If payment determined in CMS table, payment pre determined and cost report used to confirm application.
- Will compute uncompensated care payment amount on cost report if not paid in interim or new provider
- No payment made if provider did not qualify for DSH for cost reporting period



			Prior to October 1	On/After October 1	
52	34.00	Disproportionate share adjustment (see instructions)	1,107,967		34.00
53		**Uncompensated Care Adjustment**			
54			Prior to October 1	On/After October 1	
55	35.00	Total uncompensated care amount (see instructions)	0	0	35.00
56	35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
57	35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	2,173,632	35.02
58	35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	547,875	35.03
59	35.04	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	547,875		35.04
60		**Additional payment for high percentage of ESRD beneficiary discharges**			
61	40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	2,655		40.00
62	41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	325		41.00
63	42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	15.82		42.00
64	43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	500		43.00
65	44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.219780		44.00
66	45.00	Average weekly cost for dialysis treatments (see instructions)	435.60		45.00
67	46.00	Total additional payment (line 45 times line 44 times line 41)	31,116		46.00
68	47.00	Subtotal (see instructions)	10,574,584		47.00

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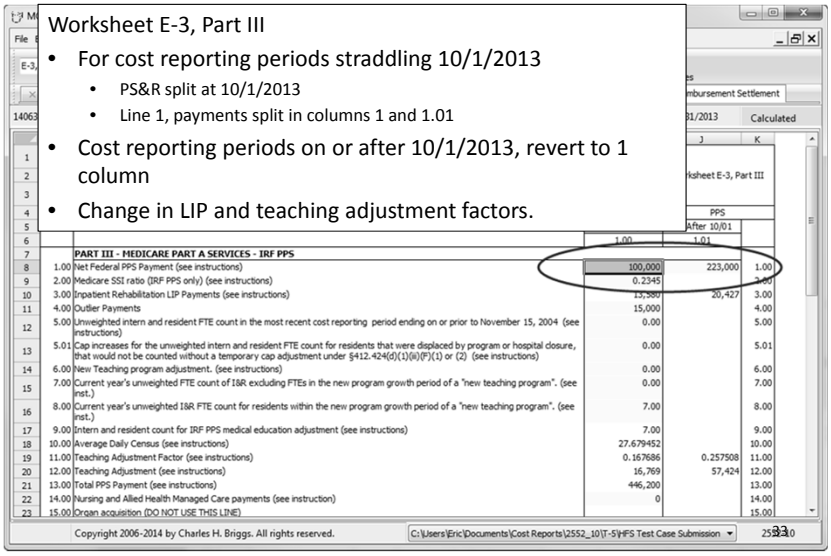
HFS System Changes



Worksheet E-3, Part III

- For cost reporting periods straddling 10/1/2013
  - PS&R split at 10/1/2013
  - Line 1, payments split in columns 1 and 1.01
- Cost reporting periods on or after 10/1/2013, revert to 1 column
- Change in LIP and teaching adjustment factors.

		1.00	1.01	
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)	100,000	223,000	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.2345		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	13,580	20,427	3.00
4.00	Outlier Payments	15,000		4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00		5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(ii)(F)(1) or (2) (see instructions)	0.00		5.01
6.00	New Teaching program adjustment. (see instructions)	0.00		6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00		7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	7.00		8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	7.00		9.00
10.00	Average Daily Census (see instructions)	27.679452		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.167686	0.257508	11.00
12.00	Teaching Adjustment (see instructions)	16,769	57,424	12.00
13.00	Total PPS Payment (see instructions)	446,200		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00

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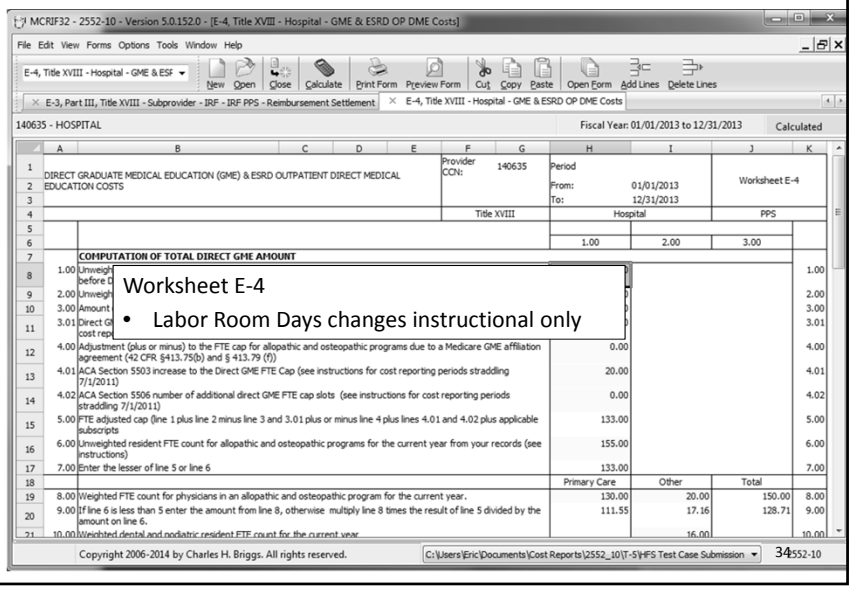
HFS System Changes



Worksheet E-4

- Labor Room Days changes instructional only

			1.00	2.00	3.00
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweigh... before D...				1.00
2.00	Unweigh...				2.00
3.00	Amount ...				3.00
3.01	Direct G... cost rep...				3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		0.00		4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)		20.00		4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)		0.00		4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts		133.00		5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		155.00		6.00
7.00	Enter the lesser of line 5 or line 6		133.00		7.00
			Primary Care	Other	Total
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.		130.00	20.00	150.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.		111.55	17.16	128.71
10.00	Weighted dental and podiatric resident FTE count for the current year			16.00	

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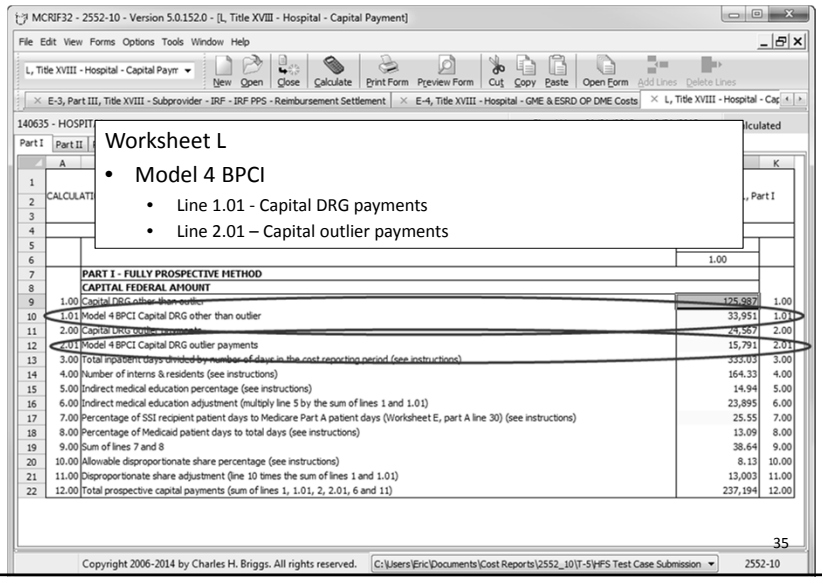
HFS System Changes



35

Data/PS&R Requirements

- Request for 10/1/2013 PS&R split critical for:
  - IPPS Hospitals with DSH
  - All IRF providers
    - LIP
    - Teaching adjustment
  - HFS PS&R reconciliation tool updated for splits
- Medicare DSH Table will assist with Uncompensated Care calculation
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Data-Files.html?DLPage=1&DLSort=0&DLSortDir=ascending

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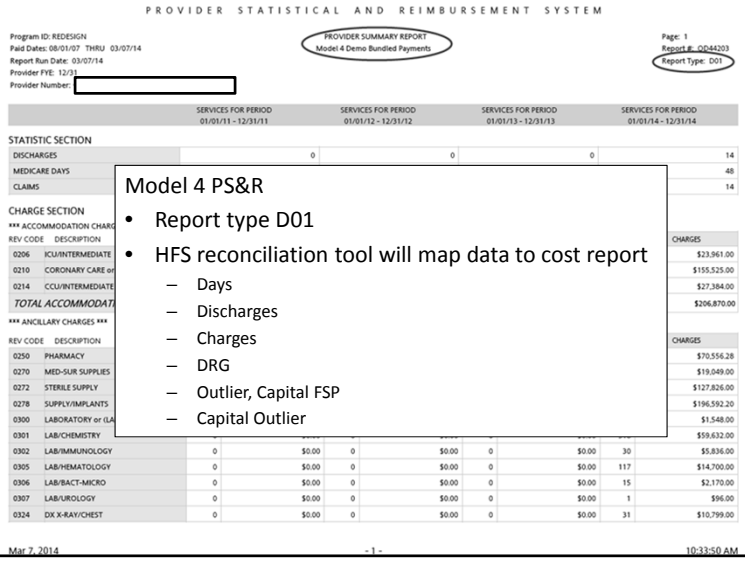
Data/PS&R Requirements



PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 03/07/14
Report Run Date: 03/07/14
Provider FYE: 12/31
Provider Number:

PROVIDER SUMMARY REPORT
Model 4 Demo Bundled Payments

Page: 1
Report #: QD44203
Report Type: D01

	SERVICES FOR PERIOD 01/01/11 - 12/31/11	SERVICES FOR PERIOD 01/01/12 - 12/31/12	SERVICES FOR PERIOD 01/01/13 - 12/31/13	SERVICES FOR PERIOD 01/01/14 - 12/31/14
STATISTIC SECTION				
DISCHARGES	0	0	0	14
MEDICARE DAYS				48
CLAIMS				14

CHARGE SECTION

*** ACCOMMODATION CHARG

REV CODE	DESCRIPTION	CHARGES
0206	ICU/INTERMEDIATE	$23,961.00
0210	CORONARY CARE or	$155,525.00
0214	CCU/INTERMEDIATE	$27,384.00
	TOTAL ACCOMMODAT	$206,870.00

*** ANCILLARY CHARGES ***

REV CODE	DESCRIPTION	CHARGES
0250	PHARMACY	$70,556.28
0270	MED-SUR SUPPLIES	$19,049.00
0272	STERILE SUPPLY	$127,826.00
0278	SUPPLY/IMPLANTS	$196,592.20
0300	LABORATORY or (LA	$1,548.00
0301	LAB/CHEMISTRY	$59,632.00
0302	LAB/IMMUNOLOGY	$5,836.00
0305	LAB/HEMATOLOGY	$14,700.00
0306	LAB/BACT-MICRO	$2,170.00
0307	LAB/UROLOGY	$96.00
0324	DX X-RAY/CHEST	$10,799.00

Mar 7, 2014 - 1 - 10:33:50 AM

Model 4 PS&R

- Report type D01
- HFS reconciliation tool will map data to cost report
  - Days
  - Discharges
  - Charges
  - DRG
  - Outlier, Capital FSP
  - Capital Outlier

37

New Edits

- Edit 12906S
  - CAHs with approved teaching will be reimbursed cost. Edit checks S-2, Part I against S-2, Part II (339 questions) and ensures there is cost.

12906S For CAHs (Worksheet S-2, Part I, line 105, column 1 is "Y"), if Worksheet S-2, Part II, column 1, line 9 is "Y", then Worksheet S-2, Part I, column 1, line 56 must also be "Y" and Worksheet A, column 7, sum of lines 21 and 22 must be greater than 0. CAHs do not complete Worksheet E-4.[06/30/2012]

38

New Edits

- Edit 129300S – If a hospital certified for meaningful use then they must enter a reporting period

12950S If Worksheet S-2, Part 1, line 167, column 1 is "Y", then line 170, column 1 must have an EHR reporting period beginning date and column 2 must have an EHR reporting period ending date. [04/01/2013s]

- Edit 13350S – Internal edit, CMS defined CBSA codes as alphanumeric

13350S If Worksheet S-4, line 20, column 1 has data then it must be five alphanumeric digits (CBSA). [05/01/2010b]

- Edit 13380S – Edit to ensure that if ESRD unit not fully prospective, correct transition years entered. HFS previously edited and corrected transition year.

13380S If Worksheet S-5, line 10.02, column 1 = "N", then line 10.03, column 2, must be 1, 2, 3, or 4 and if the cost reporting period is not the same as the calendar year then line 10.03, column 1, must be 1, 2, 3, or 4. [10/01/2012b]

39

New Edits

- Edits 1005E – 10080E
  - Multiple edits added to ensure E, Part A, lines 35-36 are properly completed based on S-2, line 22 and 22.01 data.

10005E If Worksheet S-2, Part 1, line 22, column 1, is "N", then Worksheet E, Part A, line 35.02, columns 1 and 2 and line 36 must be zero. Conversely, if Worksheet S-2, Part I, line 22, column 1, is "Y", then Worksheet E, Part A, lines 35.02 and 36 must be greater than zero. [10/01/2013]

10010E If Worksheet S-2, Part I, line 22.01, columns 1 and/or 2, is "Y", then Worksheet E, Part A, line 35 and 35.01, columns 1 and 2, respectively, must be greater than zero. [10/01/2013]

10060E If the cost reporting periods overlap October 1, 2013, then Worksheet E, Part A, line 1, must be zero. [10/01/2013]

10070E If the cost reporting period begins on or after October 1, 2013, then Worksheet E, Part A, column 1, line 1.01 and 1.02 must be zero. [10/01/2013]

10080E If cost reporting periods overlap October 1, 2013, then Worksheet E, Part A, column 1 , lines 35-35.03 must be left blank and only column 2 is to be completed. [10/01/2013]

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2552-10 T-6?

- Bipartisan Budget Act of 2013
  - Extended payment adjustments for Low Volume Adjustment and MDH providers
  - Through 3/30/2014
  - Additional information available at:
    - FR, Vol. 79, No. 52, dated March 18, 2014, page 15022
    - http://www.gpo.gov/fdsys/pkg/FR-2014-03-18/pdf/2014-05922.pdf
- Other T-6 provisions TBD

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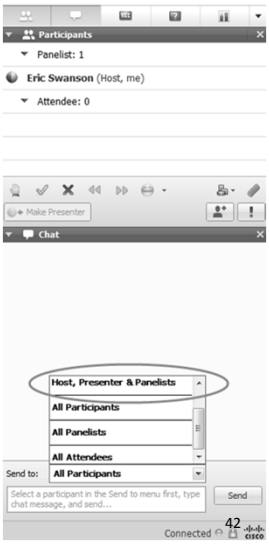
Questions?

- Use WebEx "Chat" feature



- Post WebEx email to:
  eric@hfssoft.com

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