CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11639	**Date: October 7, 2022**
	Change Request 12852

SUBJECT: Provider Specific File (PSF) changes for Direct Medical Education (DME), Direct Graduate Medical Education (DGME), Organ Acquisition Cost (OAC) and Kidney Acquisition Costs (KAC)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to enhance the Provider Specific File (PSF) that will feed the Fiscal Intermediary Shared System (FISS) in order to improve the logic needed for Direct Medical Education (DME), Direct Graduate Medical Education (DGME), Organ Acquisition Cost (OAC) and Kidney Acquisition Costs (KAC) related to the Medicare Advantage (MA) capitation rates per relevant statute.

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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**
R	3/Addendum A/ Provider Specific File

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11639	Date: October 7, 2022	Change Request: 12852

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EFFECTIVE DATE: April 1, 2023
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I. GENERAL INFORMATION

A. Background: The inpatient Provider Specific File (PSF) contains information about parameters specific to the provider that affects computations for the inpatient Prospective Payment System. The A/B Medicare Administrative Contractors (MACs) maintain the Provider Specific File (PSF).

Most of the fields on the inpatient PSF contain information about the facts specific to the provider that affect computations, e.g., effective dates for PPS, type of provider (for application of special computation rules), census division, MSA, adjusted cost per discharge, disproportionate share adjustment percentage, and capital data. Additionally, the inpatient PSF contains four "pass through fields" which represent estimated per diem amounts for non-claim payments:

- Pass Through Amount for Capital Per Diem Amount
- Pass Through Amount for Direct Medical Education Per Diem Amount
- Pass Through Amount for Organ Acquisition Per Diem Amount
- Total Pass Through Amount, Including Miscellaneous Per Diem Amount

Based on recent analysis and discussions with the Centers for Medicare, the Office of the Actuary (OACT) is requesting to provide MACs with revised guidance on calculation of two of the pass through fields on the inpatient PSF and to add two additional pass through per diem fields on the inpatient PSF to accommodate the development of the Medicare Advantage (MA) capitation rates:

1. Update instructions for development of field Pass Through Amount for Direct Medical Education Per Diem Amount. This change is being requested to ensure all MACs are using consistent instructions for development of the direct medical education per diem amount field.
2. Update instructions for development of field Pass Through Amount for Organ Acquisition Per Diem Amount. This revision is to account for requirement that MACs pay facilities kidney acquisition costs for MA enrollees, effective January 1, 2021.
3. Add new field to inpatient PSF, Pass Through Amount for Direct Graduate Medical Education Per Diem Amount. This element reflects the amount of direct graduate medical education to be excluded from MA capitation rates per regulation,
4. Add new field to inpatient PSF, Pass Through Amount for Kidney Acquisition Per Diem Amount. This element reflects the amount of kidney acquisition costs to be excluded from MA capitation rates per regulation.

B. Policy: Regulation 42 CFR 422.306 establishes the standards for development of the annual MA capitation rates.

One regulatory requirement, 42 CFR 422.306(b)(2)(ii), is that the rates be "Adjusted to exclude costs attributable to payments under section1886(h) of the Act for the costs of direct graduate medical education."

The new field on the inpatient PSF, Pass Through Amount for Direct Graduate Medical Education Per Diem Amount, will be used to calculate the carveout of direct graduate medical education from the MA capitation rates.

An additional regulatory requirement, 42 CFR 422.306(d), is that the rates are "to exclude the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title." The new field on the inpatient PSF, Pass Through Amount for Kidney Acquisition Per Diem Amount, will be used to calculate the carveout of kidney acquisition costs from the MA capitation rates.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
12852.1	The contractor shall create two new fields on the inpatient Provider Specific File (PSF) and screen(s) to allow the entry/update of the following: • **"Pass Through Amount for Direct Graduate Medical Education":** Per diem amount of direct graduate medical education to be excluded from Medicare Advantage (MA) capitation rates per regulation. • **"Pass Through Amount for Kidney Acquisition":** Per diem amount of kidney acquisition costs to be excluded from MA capitation rates per regulation.					X				IDR
12852.1.1	The contractor shall not pass these new fields to the inpatient Prospective Payment System (PPS) Pricers.					X				
12852.1.2	The contractor shall include the new fields in the PSF extract file.					X				
12852.2	The contractors shall refer to the updated cost reporting formulas provided in Attachment A of this change request, for calculation of the per diem amounts for the new "Pass Through Amount for Direct Graduate Medical Education," "Pass Through Amount for Kidney Acquisition" fields, and existing "Pass Through Amount for Direct Medical Education," and "Pass Through Amount for Organ Acquisition" fields of the PSF.	X								
12852.2.1	The contractors shall not include Data Elements 66 and 67 in the Total Pass Through Amount Field (Data	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Element 42).									
12852.2.2	The contractors should use current established process for computing the interim rates on a rolling basis during the first rate review that occurs on or after April 03, 2023.	X								
12852.2.3	The contractors shall use the latest available data in computing the rates described in Attachment A: • Contractors should use the latest as filed cost report on the last finalized settlement, • Contractors shall use the latest prospective estimates, • Contractors shall complete the per diem rate calculations using the current established process for computing the interim rates. Note: The contractors are only required to complete one rate review for DGME and organ acquisition rates per year.	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): Yvette Rivas, Yvette.rivas@cms.hhs.gov , Richard Coyle, richard.coyle@cms.hhs.gov , Richard Andrews, 410-786-6395 or richard.andrews@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

Addendum A - Provider Specific File

(Rev. 11639; Issued: 10-07-22; Effective: 04-01-23; Implementation: 04-03-23)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></tr>
<tr><td></td><td>11-16</td><td>X(6)</td><td>Provider CMS Certification Number (CCN)</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the provider CMS Certification Number (CCN) and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table></td></tr>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
Year: Greater than 82, but not greater than current year.
Month: 01-12
Day: 01-31</td></tr>
</table>

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a “Y” or “N.” Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type “06” is effective until July 1, 2006. At that point, provider type “06” will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital

Data Element	File Position	Format	Title	Description
				(during cost reporting periods that began on or after April 1, 1990). 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the *provider CMS Certification Number (CCN)* (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for

Data Element	File Position	Format	Title	Description
				payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.

Data Element	File Position	Format	Title	Description
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** For "From" dates before 1/1/2021: Enter the value to indicate if normal percentage payments should be made on RAP and/or whether payment

Data Element	File Position	Format	Title	Description
				should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments). For "From" dates on or after 1/1/2021: Enter the value to indicate whether payment should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2% **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** For cost reporting periods beginning on or after 10/01/2002, enter the appropriate code for the blend ratio between federal and facility rates for the LTCH provider: Federal % Facility% 1 20 80 2 40 60 3 60 40 4 80 20 5 100 00 For LTCH cost reporting periods beginning on or after 10/01/2015 enter the appropriate code for the blend year representing 50% site neutral payment and 50 % standard payment. **6 –Blend Year 1** (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015 through 09/30/16) **7 - Blend Years 2 through 4** (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018 or FY 2019

Data Element	File Position	Format	Title	Description
				8 - Blank – Transition Blend no longer applies with cost reporting periods beginning in on or after 10/01/2019. Full Site Neutral payment **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. Federal % Facility% 1 25 75 2 50 50 3 75 25 4 100 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible

Data Element	File Position	Format	Title	Description
				for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.

Data Element	File Position	Format	Title	Description
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for each HHA. If no factor is provided, enter 1.00000.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank)

Data Element	File Position	Format	Title	Description
				(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a “1” or “2.”
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, DSH adjustments, or Allogeneic Stem Cell Acquisition. Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A"08" is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient

Data Element	File Position	Format	Title	Description
				days. (See §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter "Y" if participating in Hospital Value Based Purchasing. Enter "N" if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter "0" if not participating in Hospital Readmissions Reduction program. Enter "1" if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter "2" if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if "1" is entered in Data Element 53. Leave blank if "0" or "2" is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a 'Y' if the hospital is subject to a reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment (UCP) amount or enter the total of the estimated per discharge UCP amount and estimated per discharge supplemental payment amount, calculated and published by CMS for each hospital. Effective 10/1/2022, the estimated per discharge supplemental payment is for eligible Indian Health Service/Tribal hospitals and hospitals located in Puerto Rico.
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated in accordance

Data Element	File Position	Format	Title	Description
				with the low-volume hospital payment regulations at § 412.101.
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	269-269	X(1)	LTCH DPP Indicator	Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.
63	270-275	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.
64	276-276	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag that certain providers may be assigned: 1=Prior Year Wage Index 2=Special IPPS-comparable Wage Index* 3=Future use Enter blank if it does not apply *Only for LTCH providers. Pricer will override the otherwise determined IPPS-comparable wage index with this value.
65	277-285	9(7)V99	Pass Through Amount for Allogeneic Stem Cell Acquisition	Enter the per diem amount based on the interim payments to the hospital. Include acquisition amounts for allogeneic stem cell transplants. Zero-fill if this does not apply.
66	*286-291*	*9(4)V9(2)*	*Pass Through Amount for Direct Medical Education (Medicare Advantage (MA) Exclusion)*	*Per diem amount of direct graduate medical education to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.*
67	*292-297*	*9(4)V9(2)*	*Pass Through Amount for Kidney Acquisition (MA Exclusion)*	*Per diem amount of kidney acquisition costs to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.*
68	*298-310*	*X(13)*	*Filler*	

Proposed formula for Direct Medical Education (DME) pass through amount field on PSF

$$\text{DME Pass Through Amount} = \left[\frac{\text{Part A DGME + Part B DGME}}{\text{Medicare FFS Days (A) + Medicare HMO Days}} + \frac{\text{Part A Misc + Part B Misc}}{\text{Medicare FFS Days (B)}} \right] \times \left[\text{Audit Adjustment Factor} \right]$$

Item	Cost Report Field	Cost Report Location
Part A DGME	Part A Medicare GME payment	Worksheet E-4, line 49, column 1
Part B DGME	Part B Medicare GME payment	Worksheet E-4, line 50, column 1
Part A Misc	Nursing and allied health managed care payment + Cost of physicians' services in a teaching hospital + Routine service other pass through costs + Ancillary service other pass through costs	Worksheet E Part A, line 53, column 1 Worksheet E Part A, line 56, column 1 Worksheet E Part A, line 57, column 1 Worksheet E Part A, line 58, column 1
Part B Misc	Ancillary service other pass through costs + Interns and residents + Cost of physicians' services in a teaching hospital	Worksheet E Part B, line 9, column 1 Worksheet E Part B, line 22, column 1 Worksheet E Part B, line 23, column 1
Medicare FFS days (A)	Hospital adults & pediatrics days + Specialty care hospital units Subprovider - IPF and IRF + Labor & delivery days	Worksheet S-3 Part I, line 1, column 6 Worksheet S-3 Part I, lines 8-12, column 6 Worksheet S-3 Part I, line 16-17, column 6 Worksheet S-3 Part I, line 32, column 6
Medicare FFS days (B)	Hospital adults & pediatrics days + Specialty care hospital units + Labor & delivery days	Worksheet S-3 Part I, line 1, column 6 Worksheet S-3 Part I, lines 8-12, column 6 Worksheet S-3 Part I, line 32, column 6
Medicare HMO days	HMO and other days + HMO IPF Subprovider days + HMO IRF Subprovider days	Worksheet S-3 Part I, line 2, column 6 Worksheet S-3 Part I, line 3, column 6 Worksheet S-3 Part I, line 4, column 6
Audit Adj. Factor	AAF is not on cost report. Factor is developed by MACs based on provider-specific experience.	

Proposed formula for Organ Acquisition Cost (OAC) pass through amount field on PSF

$$\text{OAC Pass Through Amount} = \left[\frac{\text{Kidney Acquisition Costs}}{\text{Medicare FFS Days + Medicare HMO Days}} + \frac{\text{Non-Kidney Acquisition Costs}}{\text{Medicare FFS Days}} \right] \mathbf{x} \left[\text{Audit Adjustment Factor} \right]$$

Item	**Cost Report Field**	**Cost Report Location**
Kidney Acquisition Costs	Net Kidney Acquisition Costs	Worksheet D-4 (Kidney), Part III, line 69, column 1
Non-Kidney Acquisition Costs	Net Heart Acquisition Costs +	Worksheet D-4 (Heart), Part III, line 69, column 1
	Net Liver Acquisition Costs +	Worksheet D-4 (Liver), Part III, line 69, column 1
	Net Pancreas Acquisition Costs +	Worksheet D-4 (Pancreas), Part III, line 69, column 1
	Net Lung Acquisition Costs +	Worksheet D-4 (Lung), Part III, line 69, column 1
	Net Intestine Acquisition Costs +	Worksheet D-4 (Intestine), Part III, line 69, column 1
	Net Islet Acquisition Costs +	Worksheet D-4 (Islet), Part III, line 69, column 1
	Other Net Acquisition Costs	Worksheet D-4 (Other), Part III, line 69, column 1
Medicare FFS days	Hospital adults & pediatrics days +	Worksheet S-3 Part I, line 1, column 6
	Specialty care hospital units	Worksheet S-3 Part I, lines 8-12, column 6
Medicare HMO days	HMO and other days	Worksheet S-3 Part I, line 2, column 6
Audit Adj. Factor	AAF is not on cost report. Factor is developed by MACs based on provider-specific experience.	

Proposed formula for Direct Graduate Medical Education (DGME) pass through amount field on PSF

$$\text{DGME Pass Through Amount} = \left[\frac{\text{Part A DGME + Part B DGME}}{\text{Medicare FFS Days + Medicare HMO Days}} \right] \times \left[\text{Audit Adjustment Factor} \right]$$

Item	Cost Report Field	Cost Report Location
Part A DGME	Part A Medicare GME payment	Worksheet E-4, line 49, column 1
Part B DGME	Part B Medicare GME payment	Worksheet E-4, line 50, column 1
Medicare FFS days	Hospital adults & pediatrics days + Specialty care hospital units Subprovider - IPF and IRF + Labor & delivery days	Worksheet S-3 Part I, line 1, column 6 Worksheet S-3 Part I, lines 8-12, column 6 Worksheet S-3 Part I, line 16-17, column 6 Worksheet S-3 Part I, line 32, column 6
Medicare HMO days	HMO and other days + HMO IPF Subprovider days + HMO IRF Subprovider days	Worksheet S-3 Part I, line 2, column 6 Worksheet S-3 Part I, line 3, column 6 Worksheet S-3 Part I, line 4, column 6
Audit Adj. Factor	AAF is not on cost report. Factor is developed by MACs based on provider-specific experience.	

Proposed formula for Kidney Acquisition Cost (KAC) pass through amount field on PSF

$$\text{KAC Pass Through Amount} = \left[\frac{\text{Kidney Acquisition Costs}}{\text{Medicare FFS Days} + \text{Medicare HMO Days}} \right] \times \left[\text{Audit Adjustment Factor} \right]$$

Item	Cost Report Field	Cost Report Location
Kidney Acquisition Costs	Net Kidney Acquisition Costs	Worksheet D-4 (Kidney), Part III, line 69, column 1
Medicare FFS days	Hospital adults & pediatrics days + Specialty care hospital units	Worksheet S-3 Part I, line 1, column 6 Worksheet S-3 Part I, lines 8-12, column 6
Medicare HMO days	HMO and other days	Worksheet S-3 Part I, line 2, column 6
Audit Adj. Factor	AAF is not on cost report. Factor is developed by MACs based on provider-specific experience.	

Notes:

1. The pass through amount per diem fields should be calculated and included on the inpatient PSF for TEFRA, IPF and IRF.

2. The Audit Adjustment Factor (AAF) is an amount calculated by the MACs that represents the ratio of a cost report element from a most recent audited cost report relative to the corresponding value on the filed cost report. MACs may use a default AAF of 1.0.

3. The inclusion of Part B expenditures in DME and DGME pass through formulas results in different trust funds being represented in numerator and denominator of per diem field. However, it is important to capture the Part B costs in a per diem field and no pass through fields are include on the outpatient provider specific file (PSF).