# Program Memorandum Intermediaries

**Department of Health and Human Services (DHHS)**
**HEALTH CARE FINANCING ADMINISTRATION (HCFA)**

**Transmittal A-00-66** **Date: SEPTEMBER 18, 2000**


**CHANGE REQUEST 1331**

**SUBJECT: FY 2001 Prospective Payment System (PPS) Hospital and Other Bill Processing Changes**

This Program Memorandum (PM) outlines changes for inpatient PPS hospitals for FY 2001. The changes for FY 2001 were published in the ***Federal Register*** on August 1, 2000. All items covered in this PM are effective for hospital discharges occurring on or after October 1, 2000 unless otherwise noted. **Inform the affected hospitals of these changes.**

## I. ICD-9-CM Changes

ICD-9-CM coding changes are effective October 1, 2000. The coding changes are available in Tables 6a and 6b in the addendum to the final rule for PPS changes for FY 2001. Invalid codes are contained in Table 6c and 6d, and revised diagnosis code titles are in Table 6e of the same final rule.

GROUPER 18.0 assigns Diagnosis Related Groups (DRGs) based on the revised ICD-9-CM codes effective with discharges occurring on or after October 1, 2000. Medicare Code Editor (MCE) 17.0 and Outpatient Code Editor (OCE) versions 16.0 and 1.10 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2001.

## II. Furnished Software Changes

The following software programs were issued for FY 2001:

- **PRICER 01.0** for discharges occurring on or after October 1, 2000. This processes bills with discharge dates on or after October 1, 1996.

The standardized amount update factor is 3.4 percent for sole community hospitals and 2.3 percent for all other hospitals.

The hospital specific update factor is 3.4 percent for sole community hospitals and 2.3 percent for all other hospitals.

The common fixed loss cost outlier threshold in FY 2000 is equal to the PPS rate for the DRG plus $17,550 ($16,036 for hospitals that have not yet entered PPS for capital-related costs). The marginal cost factor for cost outliers remains 80 percent.

The FY 2001 Federal capital rate is $382.03, the Puerto Rico rate is $185.06.

The FY 2001 outlier adjustment factors are 0.948908 for the operating standardized amount, and 0.9409 for the capital Federal rate. The FY 2001 outlier adjustment factors for Puerto Rico are 0.974791 for the operating standardized amount and 0.9699 for the capital Federal rate.

Payments under the DSH provision are reduced by 3.0 percent in FY 2001.

The indirect medical education (IME) formula is 1.54*((1+ the intern to bed ratio)**.405-1) for FY 2001.

The revised hospital wage indexes and geographic adjustment factors are contained in Tables 4a (urban areas), 4b (rural areas) and 4c (redesignated hospitals) of section VI of the addendum to the PPS final rule.

o **Grouper 18.0** for discharges occurring on or after October 1, 2000. PRICER calls the appropriate Grouper based on discharge date; and

o **MCE 17.0** for discharges occurring on or after October 1, 2000, and **OCE 16.0 and 1.10** for services furnished on or after October 1, 2000. These replace earlier versions and contain complete tables driven by date. MCE and OCE select the proper internal tables based on discharge date.

## III. System Changes You Must Make

o **For all fully prospective (Capital Type C) hospitals**, create a new record with an effective date of October 1, 2000 and adjust the Hospital Specific Capital Rate Field (positions 186-191) on the Provider Specific File (PSF) by multiplying the amount in the previous record by .9823. This represents an adjustment of .9784 for FY 94, 1.0005 for FY 95, 1.2110 for FY 96, .9568 for FY 97, .8563 for FY 98, 1.0138 for FY 99 and .9976 for FY 00. PRICER will make the FY 01 adjustment of 1.0147.

o Update the provider (PROV) file for each hospital as needed effective October 1, 2000, and effective with the cost reporting period that begins on or after October 1, 2000. At a minimum, update the following fields:

- Intern/beds ratio;
- Hospital beds;
- Operating cost-to-charge ratio;
- Fiscal year beginning date;
- Pass through amounts (for non-PPS and new hospitals);
- SSI ratio
- Medicaid ratio;
- Change code for wage index reclassification: enter "N" if a hospital has not been reclassified for Federal FY 2001, or a "Y" if it has;
- If a hospital has been reclassified for FY 2001, update the wage index and standardized amount location Metropolitan Statistical Areas (MSAs);
- Old capital hold-harmless rate;
- New capital hold-harmless rate;
- Capital cost-to-charge ratio;
- New hospital indicator: overlay the "Y" with a blank if a hospital is no longer in its first 2 years of operation;
- Capital indirect medical education ratio; and
- Capital exception payment rate (as applicable).

o Tables 8a and 8b of section VI of the addendum to the PPS final rule contain the FY 2001 statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when you are unable to compute a reasonable hospital-specific cost-to-charge ratio.

o MSA reclassifications. Enter standardized amount and wage index reclassifications issued by the Medicare Geographic Classification Review Board (MGCRB) effective October 1, 2000, into the PSF. The reclassification list can be found at www.hcfa.gov/stats/pufiles.htm. Actual geographic location MSA data is found in file positions 59-62. Use file positions 63-66 to record

any wage index location MSA to which a hospital was reassigned. Record the standardized amount location MSA to which a hospital was reassigned in file positions 67-70. Enter a "Y" in file position 58 if there was a wage index reclassification for FY 2001, or an "N" if there was not a reclassification. Enter an "N" for providers with an entry in the hold harmless column. If a provider is reclassified for standardized amount to an MSA in a different census division, change the census division in the PROV file to match the new MSA.

## IV. Other Changes

All sole community hospitals (SCHs). Create a new record with an effective date of October 1, 2000, and adjust the Case Mix Adjusted Cost Per Discharge/ Facility Specific Rate field (positions 81-87) on the PSF as indicated in the four steps below.

Case Mix Adjusted Cost Per Discharge/ Facility Specific Rate

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period: the Federal national rate applicable to the hospital; or the hospital's "target amount" that is, either the updated hospital-specific rate based on FY 1982 costs per discharge, or the updated hospital-specific rate based on FY 1987 costs per discharge. Essential access community hospitals (provider types 21 and 22) are treated as SCHs (provider types 16 and 17) for payment purposes and are included with SCHs in the following policy.

Section 405 of Public Law 106-113, which amended §1886(b)(3) of the Act, provides that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its FY 1982 or FY 1987 target amount (the hospital-specific rate as opposed to the Federal rate) may elect to receive payment under a methodology using a third hospital-specific rate based on the hospital's FY 1996 costs per discharge. This amendment to the statute means that, for discharges occurring in cost reporting periods beginning on or after October 1, 2000, eligible SCHs can elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

When calculating an eligible SCH's FY 1996 hospital-specific rate, use the same basic methodology used to calculate FY 1982 and FY 1987 bases. That methodology is set forth in §§412.71 through 412.75 of the regulations and discussed in detail in several prospective payment system documents published in the ***Federal Register*** on September 1, 1983 (48 FR 3977); January3, 1984 (49 FR 256); June 1, 1984 (49 FR 23010); and April 20, 1990 (55 FR 15150).

Since we anticipate that eligible hospitals will elect the option to rebase using their FY 1996 cost reporting periods, identify those SCHs that were paid for their cost reporting periods beginning during calendar year 1999 on the basis of their target amounts. For these hospitals, calculate the FY 1996 hospital-specific rate as described below. If this rate exceeds the current target amount based on the greater of the FY 1982 or FY 1987 hospital-specific rate, the hospital will receive payment based on the FY 1996 hospital-specific rate (blended as specified below) unless the hospital notifies you in writing prior to the end of its cost reporting period that it does not wish to be paid on the basis of its FY 1996 hospital-specific rate. Thus, if a hospital does not notify you before the end of its cost reporting period that it declines the rebasing option, we would deem the lack of such notification as an election to rebase.

An SCH's decision to decline this option for a cost reporting period will remain in effect for subsequent periods until such time as the hospital notifies you otherwise.

The FY 1996 hospital-specific rate will be based on FY 1996 cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996, that are 12 months or longer. If the hospital's last cost reporting period ending on or before September 30, 1996, is less than 12 months, use the hospital's most recent 12-month or longer cost reporting period ending before the short period report. If a hospital has no cost reporting period beginning in FY 1996, it would not have a hospital-specific rate based on FY 1996.

For each hospital eligible for FY 1996 rebasing, calculate a hospital-specific rate based on the hospital's FY 1996 cost report as follows:

o Determine the hospital's total allowable Medicare inpatient operating cost, as stated on the FY 1996 cost report.

o Divide the total Medicare operating cost by the number of Medicare discharges in the cost reporting period to determine the FY 1996 base period cost per case. For this purpose, transfers are considered to be discharges.

o In order to take into consideration the hospital's individual case-mix, divide the base year cost per case by the hospital's case-mix index applicable to the FY 1996 cost reporting period. This step is necessary to standardize the hospital's base period cost for case-mix and is consistent with our treatment of both FY 1982 and FY 1987 base-period costs per case. A hospital's case-mix is computed based on its Medicare patient discharges subject to DRG-based payment.

Notify eligible hospitals of their FY 1996 hospital-specific rate prior to October 1, 2000. Consistent with our policies relating to FY 1982 and FY 1987 hospital-specific rates, hospitals are permitted to appeal a fiscal intermediary's determination of the FY 1996 hospital-specific rate under the procedures set forth in 42 CFR part 405, subpart R, which concern provider payment determinations and appeals. In the event of a modification of base period costs for FY 1996, rebasing due to a final nonappealable court judgment or certain administrative actions (as defined in §412.72(a)(3)(i)), the adjustment will be retroactive to the time of your initial calculation of the base period costs, consistent with the policy for rates based on FY 1982 and FY 1987 costs.

The Case Mix Adjusted Cost per Discharge/Facility Specific Rate field of the Provider Specific File currently contains the greater of the hospital's FY 1982 or FY 1987 hospital specific rate updated to 1994. You must perform the following steps to update this field for discharges occurring in FY 2001 and thereafter so Pricer will correctly calculate payments.

STEP 1 -- Multiply the amount currently in the Case Mix Adjusted Cost per Discharge/Facility Specific Rate field by a factor of 1.055424 to update it from 1994 to 2000. This represents a budget neutrality adjustment of .999851 for FY93, .999003 for FY 94, .998050 for FY 95, .999306 for FY 96, .998703 for FY 97, .997731 for FY 98, .998978 for FY 99 and .997808 for FY 00 and an update factor adjustment of 1.014 for FY 95, 1.015 for FY 96, 1.020 for FY 97, 1.000 for FY 98, 1.005 for FY 99 and 1.011 for FY 00. PRICER will make the FY 01 adjustment of 1.023 for Medicare Dependent Hospitals (MDH) and 1.034 for SCH's as well as the Outlier adjustment factor of .948908.

STEP 2 -- If the hospital is an SCH eligible to rebase based on 1996 costs and does not decline rebasing, multiply its FY 1996 amount (identified in the statute as the "rebased target amount") by a factor of 1.02547 to update it from 1996 to 2000.

STEP 3 -- If the hospital is not an SCH or is an SCH that either is not eligible to rebase or elects not to do so, or is an SCH eligible to rebase based on 1996 costs that does not decline rebasing but whose cost reporting period does not begin on October 1, 2000, enter the amount from STEP 1 in the Case Mix Adjusted Cost per Discharge/Facility Specific Rate field.

STEP 4 -- If the hospital is an SCH eligible to rebase based on 1996 costs and does not decline rebasing, at the beginning of its cost reporting period beginning on or after October 1, 2001, enter the sum of 75 percent of the amount from STEP 1 plus 25 percent of the amount from STEP 2 in the Case Mix Adjusted Cost per Discharge / Facility Specific Rate field. For Federal fiscal years 2002, 2003 and 2004, update this field as follows:

o Effective October 1, 2001, enter the sum of 50 percent of the amount from STEP 1 plus 50 percent of the amount from STEP 2.

- Effective October 1, 2002, enter the sum of 25 percent of the amount from STEP 1 plus 75 percent of the amount from STEP 2.
- Effective October 1, 2003, enter 100 percent of the amount from STEP 2.

**The *effective date* for this Program Memorandum (PM) is 10/1/00.**

**The *implementation date* for this PM is 10/1/00.**

**These instructions should be implemented within your current operating budget.**

**This PM may be discarded after 9/30/01.**

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