# Program Memorandum Intermediaries

**Department of Health and Human Services (DHHS)**

**HEALTH CARE FINANCING ADMINISTRATION (HCFA)**

**Transmittal No. A-00-17** **Date: APRIL 2000**


**CHANGE REQUEST 1129**

**SUBJECT: Changes to FY 2000 Hospital Inpatient Prospective Payment System (PPS) Policies As Required by the Medicare, Medicaid, and State-Child Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA), P.L. 106-113**

The BBRA, enacted on November 29, 1999 contained numerous provisions affecting inpatient hospital payment policies. Many of these provisions do not become effective until fiscal year (FY) 2001, and in some cases even later. However, a number of BBRA provisions became effective retroactively prior to the passage of BBRA, or shortly after its passage. This Program Memorandum is to notify you of some of these provisions and the actions you are to take to implement them. In some cases, further policy development will be necessary and further instructions will be forthcoming. Although a number of provisions cannot be implemented at this time, they are described here nonetheless in order to apprise you of their status.

**Indirect Medical Education**

Section 111(a) of the BBRA modified the transition for the Indirect Medical Education (IME) adjustment that was established by the Balanced Budget Act of 1997 (BBA). Specifically, the formula multipliers[1] under the previous transition schedule for discharges occurring during FY 2000 and later were as follows:

- For discharges occurring during FY 2000 — 1.47; and
- For discharges occurring on or after October 1, 2000 — 1.35.

The new transition schedule is:

- For discharges occurring during FY 2000 — 1.6;
- For discharges occurring during FY 2001 — 1.54; and
- For discharges occurring on or after October 1, 2001 — 1.35.

Section 111(b) provides for special payments to implement the retroactive increase in the multiplier for FY 2000. Under this subsection, these changes are not to affect any other payments, determinations, or budget neutrality adjustments. Therefore, the revision for FY 2000 will not be incorporated into PRICER. It will instead be necessary to estimate the additional IME payments hospitals will receive and make interim adjustments on that basis. The final IME payments will be determined on the cost reports. Dividing the IME adjustment that a hospital would receive using the 1.6 post-BBRA multiplier instead of the 1.47 pre-BBRA multiplier yields a quotient of 1.0884354. For example, if a hospital's IRB ratio is .1, and 1.47 is the factor used, the IME adjustment factor would be .0578523. When 1.6 is used as the multiplier, the product is .0629685. Dividing .0629685 by .0578523 yields a quotient of 1.0884354. Therefore, the incremental IME payments due to teaching hospitals because of the BBRA change can be estimated by increasing the amount calculated by PRICER by a factor of 1.0884354. To implement this change all IME payments during

[1] The formula multiplier is represented as $c$ in the following equation used to calculate the IME adjustment factor: $c \times [(1+r)^{.405} - 1]$. The variable $r$ represents the hospital's resident-to-bed ratio.

FY 2000 should be adjusted in this manner.

**Exception to the Case Mix Index Qualifier for Rural Referral Center Status**

For FY 2000, §151 of the BBRA authorized an exception to the statutory case mix index required for designation as a rural referral center (RRC) for Northwest Mississippi Regional in Clarksdale, MS. Therefore, from October 1, 1999 through September 30, 2000, Northwest Mississippi Regional Center is considered to be a RRC. The intermediary for this hospital has been notified.

**Reclassification of Certain Counties**

Sections 152, 153, and 154 of the BBRA contain provisions that reclassify hospitals in certain counties for PPS payment purposes effective for discharges occurring on or after October 1, 1999. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index, as well as capital geographic adjustment factors, including large urban add-on, where appropriate (see §412.316). We have recalculated FY 2000 wage indexes for hospitals in the affected counties, and these are listed in the table below. No other hospitals' wage indexes were affected, including those in the areas to which these hospitals were reclassified.

Under §152, hospitals in the following counties are reclassified for FYs 2000 and 2001:

- Iredell County, North Carolina is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina Metropolitan Statistical Area (MSA);

- Orange County, New York is deemed to be located in the New York, NY MSA;

- Lake County, Indiana and Lee County, Illinois are deemed to be located in the Chicago, IL MSA;

- Hamilton-Middletown, Ohio is deemed to be located in the Cincinnati, OH-KY-IN MSA;

- Brazoria County, Texas is deemed to be located in the Houston, TX MSA;

- Chittenden County, Vermont is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH MSA.

Under §153, the Hattiesburg, MS MSA wage index was recalculated by including the wage data for Wesley Medical Center for FY 2000. Under §154, the Allentown-Bethlehem-Easton, PA MSA wage index was recalculated by including the wage data for Lehigh Valley Hospital for FYs 2000 and 2001.

The following table shows the changes to the FY 2000 wage index values for the affected hospitals. The MSAs in the table are the MSAs applicable for wage index assignment, not necessarily the MSA where the hospital is geographically located. In some cases, hospitals were already reclassified by the Medicare Geographic Classification Review Board for wage index purposes. Hospitals affected by §152 of the BBRA will now also be considered reclassified for purposes of the standardized amount.

We believe this is a comprehensive list of affected hospitals. However, if there are other hospitals located in the counties mentioned above, these should be treated similarly to other hospitals in their county.

| Provider | Old MSA (for Wage Index Only* denotes rural) | Old Wage Index | New MSA (for Wage Index and Standardized Amount) | New Wage Index |
|---|---|---|---|---|
| 140012 | 1600 | 1.0872 | 1600 | 1.0750 |
| 150002 | 2960 | 0.9369 | 1600 | 1.0750 |
| 150004 | 2960 | 0.9369 | 1600 | 1.0750 |
| 150008 | 2960 | 0.9369 | 1600 | 1.0750 |
| 150034 | 2960 | 0.9369 | 1600 | 1.0750 |
| 150090 | 2960 | 0.9369 | 1600 | 1.0750 |
| 150125 | 2960 | 0.9369 | 1600 | 1.0750 |
| 150126 | 1600 | 1.0872 | 1600 | 1.0750 |
| 150132 | 2960 | 0.9369 | 1600 | 1.0750 |
| 250078 | 3285 | 0.7306 | 3285 | 0.7634 |
| 330001 | 5640 | 1.0772 | 5600 | 1.4342 |
| 330126 | 5640 | 1.0772 | 5600 | 1.4342 |
| 330135 | 5640 | 1.0772 | 5600 | 1.4342 |
| 330205 | 5640 | 1.0772 | 5600 | 1.4342 |
| 330209 | 5640 | 1.0772 | 5600 | 1.4342 |
| 330264 | 5640 | 1.0772 | 5600 | 1.4342 |
| 340039 | 3290 | 0.9148 | 1520 | 0.9434 |
| 340129 | * | 0.8290 | 1520 | 0.9434 |
| 340144 | 1520 | 0.9433 | 1520 | 0.9434 |
| 360046 | 3200 | 0.8989 | 1640 | 0.9419 |
| 360056 | 1640 | 0.9434 | 1640 | 0.9419 |
| 360076 | 3200 | 0.8989 | 1640 | 0.9419 |
| 360132 | 3200 | 0.8989 | 1640 | 0.9419 |
| 390019 | 0240 | 0.9550 | 0240 | 1.0228 |
| 390049 | 0240 | 0.9550 | 0240 | 1.0228 |
| 390162 | 0240 | 0.9550 | 0240 | 1.0228 |
| 390194 | 0240 | 0.9550 | 0240 | 1.0228 |
| 390197 | 0240 | 0.9550 | 0240 | 1.0228 |
| 390263 | 0240 | 0.9550 | 0240 | 1.0228 |
| 450065 | 1145 | 0.8516 | 3360 | 0.9388 |
| 450072 | 1145 | 0.8516 | 3360 | 0.9388 |
| 450591 | 1145 | 0.8516 | 3360 | 0.9388 |
| 470003 | 1303 | 1.0558 | 1123 | 1.1359 |

Implement the new FY 2000 wage index values upon receipt of this memorandum by making accelerated payments based on the new wage indexes published above until the availability of PRICER 00.1 (estimated release date, May 2000). Change the provider specific file for each provider listed above so that their wage index and standardized amount MSAs are equal to the New MSA listed above and code a "Y" in the change code for wage index reclassification prior to processing these claims through the new PRICER. Intermediaries must also use the new PRICER to reprocess, through debit-credit adjustments, discharges on or after October 1, 1999 and before implementation of the new PRICER software.

**Urban Hospitals Electing Rural Status**

Section 401 of the BBRA enumerates criteria for determining whether an urban hospital will be able to elect reclassification as a rural hospital.

In order to qualify for this reclassification, a hospital must satisfy one of the following criteria:

- The hospital is located in a rural census tract of a MSA as determined under the most recent Goldsmith Modification, originally published in the February 27, 1992 ***[Federal Register ](57 FR 6725)***;

- The hospital is located in an area designated by any law or regulation of its State as a rural area (or designation by such State as a rural hospital);

- The hospital would qualify as a rural, regional, or national referral center or as a sole community hospital under existing regulations, if it were located in a rural area; or

- The hospital meets other criteria specified by the Secretary.

Hospitals qualifying for this reclassification under the above criteria shall also be treated as rural for their outpatient services. Additionally, a State has the option of designating a facility that is reclassed under 1886(d)(8)(E) as a critical access hospital because the facility would be treated as being located in a rural area under this provision.

An urban hospital qualifying under this section shall be treated as being located in the rural area of its State no later than 60 days after the RO receives its application for reclassification.

This provision became effective on January 1, 2000. Further clarification will be forthcoming separately from HCFA.

**Update of Standards Applied for Geographic Reclassification for Certain Hospitals**

Section 402 (Update of Standards Applied for Geographic Reclassification for Certain Hospitals) allows those hospitals that fall under §1886(d)(8)(B) of the Act to elect to utilize standards published in the ***[Federal Register]*** on March 30, 1990 by the Office of Management and Budget (OMB) instead of standards published in the ***[Federal Register]*** on January 3, 1980 by OMB. While the legislation is effective for discharges occurring on or after October 1, 1999, it only allows the choice of standards during FY 2001 and FY 2002. Prior to October 1, 2000, hospitals continue to be required to use the standards published in the ***[Federal Register]*** dated January 3, 1980. After September 30, 2002, they must use data based on the 2000 census. HCFA will identify, based on OMB analysis, those hospitals affected by this provision.

**Critical Access Hospitals (CAH)**

Section 403 of BBRA mandated the following changes in the critical access hospital (CAH) program:

The 96-hour limit. Previous law required that a CAH discharge or transfer each inpatient within 96 hours after admission. As of November 29, 1999, a CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient. The CAH's average length of stay will be calculated by its intermediary based on patient census data and reported to the RO. If a CAH exceeds the average length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the RO, or face termination of its Medicare provider agreement.

Because of this change, effective November 29, 1999, CAHs are no longer required to obtain documentation showing that individual stays longer than 96 hours were needed because of inclement weather or other emergency conditions, or to obtain a case-specific waiver of the 96-hour limit from a peer review organization (PRO) or equivalent entity.

For-profit hospitals: Previous law allowed CAH status only for public or nonprofit hospitals. The amendment permits for-profit hospitals to qualify for designation as CAHs should other statutory and regulatory requirements be met.

A closed or downsized hospital may qualify as a CAH: The provision allows a State to designate as a CAH a facility that was a hospital but ceased operations on or after November 29, 1989 (10 years prior to the enactment of the BBRA), should that facility fulfill statutory and regulatory criteria as of the effective date of its designation. Conforming changes to the regulations will follow.

A State may designate a health clinic or health center as a CAH: The provision allows a State to designate a health clinic or health center as a CAH if this facility is licensed by the State as a health clinic or health center, and it was a hospital prior to its downsizing to this present level, and if it meets the statutory and regulatory criteria as a CAH, as of the date of its designation.

Conforming changes to the regulations will follow.

**Medicare Dependent Hospitals**

Section 404 extended the Medicare-dependent, small rural hospital (MDH) provision, as defined in §1886 (d)(5)(G), for 5 additional years, to encompass cost reporting periods beginning before October 1, 2006. Conforming changes to the regulations will follow.

**Sole Community Hospitals**

For cost reporting periods beginning on or after October 1, 2000, §405 of the BBRA authorizes a sole community hospital (SCH) that was paid for its cost reporting period beginning nor after October 1, 2000 on the basis of either its **1982** or **1987** target amount (the facility's hospital- specific rate [HSR] as opposed to the federal rate), to rebase to **1996.** This means that for cost reports beginning in FY 2001, such hospitals have the option of using the allowable FY 1996 operating costs for inpatient hospital services as the base year for the HSR rather than their 1982 or 1987 costs.

The fundamental step that you must take is to identify those SCHs eligible for rebasing, those SCHs that were paid on the basis of their HSR for cost reporting periods during 1999. For hospitals that will be paid using a 1996 HSR, the following formula will determine the HSR over 3 years, from FY 2001 to FY 2003:

For discharges during FY 2001, the applicable HSR will be the sum of:
75 percent of the 1982 or 1987 HSR
25 percent of the 1996 HSR.

For discharges during FY 2002, the applicable HSR will be the sum of::
50 percent of the 1982 or 1987 HSR
50 percent of the 1996 HSR.

For discharges during FY 2003, the applicable HSR will be the sum of:
25 percent of the 1982 or 1987 HSR
75 percent of the 1996 HSR.

For discharges during FY 2004 or any subsequent fiscal year, the applicable HSR will be 100 percent of the 1996 amount.

Specific implementing instructions for this provision will be forthcoming separately from HCFA.

**Counting Residents for Indirect and Direct Graduate Medical Education**

Counting primary care residents on certain approved leaves of absence in the base-year full-time equivalent (FTE) count §407(a) of the BBRA directs the Secretary to count an individual for purposes of determining a hospital's 1996 FTE cap, to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. This provision applies to both direct and indirect graduate medical education (GME) FTE counts and allows a hospital to receive a permanent adjustment to its individual FTE cap up to three additional FTE residents. This change in FTE caps is effective for direct GME with cost reporting periods that begin on or after the date of enactment of the BBRA, November 29, 1999, and for discharges occurring after that date for purposes of IME (both operating and capital).

Further implementing instructions for this provision will be forthcoming separately from HCFA.

Permitting 30 percent expansion in current GME training programs for hospitals located in rural areas Section 407(b) of the BBRA permits a 30 percent expansion of a rural hospital's direct and indirect FTE count for purposes of establishing the hospital's individual 1996 FTE cap. Specifically, for purposes of establishing a rural hospital's FTE cap, §407(b) allows that the FTE count may not exceed 130 percent of the number of residents the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996.

For example, if a hospital located in a rural area had 10 FTEs for its count for both direct and indirect GME in its most recent cost reporting period ending on or before December 31, 1996, under this new provision, the hospital would have a 1996 FTE cap of 13 FTEs, instead of 10 FTEs, because the hospital is located in a rural area. The revised FTE cap is based on 130 percent of the number of residents in its most recent cost reporting period ending on or before December 31, 1996 and a 130 percent of 10 FTEs is 13 FTEs.

This change is effective with cost reporting periods beginning on or after April 1, 2000 for direct GME, and discharges occurring on or after April 1, 2000 for IME (both operating and capital).

Not counting against numerical limitation certain interns and residents transferred from a Department of Veterans Affairs hospital's residency program that loses accreditation Section 407(d) of the BBRA addressed the situation where residents were training in a residency training program at a Department of Veterans Affairs (Hospital A) and then were transferred on or after January 1, 1997 and on or before July 30, 1998, to a non-Veterans Affairs hospital (Hospital B) because the program in which the residents were training would lose its accreditation if the residents continued to train at Hospital A. In this scenario, Hospital B may receive a temporary adjustment to its 1996 FTE cap to include in its FTE count those residents who were transferred to Hospital B for the time that those transferred residents were training at Hospital B.

This policy is effective as if included in the enactment of the BBA, that is, for direct GME with cost reporting periods beginning on or after October 1, 1997 and for IME payments (both operating and capital) for discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments shall be made immediately, and no later than 60 days after the enactment of the BBRA.

**Initial Residency Period For Child Neurology Residency Programs**

Section 1886(h)(5)(F) of the Social Security Act (the Act) defines the term "initial residency period" to mean the "period of board eligibility." The "period of board eligibility" is defined in §1886(h)(5)(G) of the Act as the period recognized by the Accreditation Council on Graduate Medical Education (ACGME) as specified in the *Graduate Medical Education Directory* published by the American Medical Association. Therefore, the statute directs us to base the initial residency period on the minimum time required for a resident to become board eligible in a specialty and the

published periods included in the *Graduate Medical Education Directory*. During the initial residency period, the residents are weighted at 1.0 full-time equivalent (FTE) for purposes of Medicare payment. Residents in training beyond their initial residency period are weighted at 0.5 full time equivalents.

To ensure that a hospital may receive full payment for all five years of training a resident in child neurology, Congress has included a provision in the BBRA at §312 which aligns the number of years required to become board-eligible in child neurology with the statute regarding initial residency periods. Section 1886(h)(5) of the Act is amended at the end by the addition of clause (v) which states that, "in the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years." Therefore, the period of board eligibility and the initial residency period for child neurology is now 5 years, and the resident would be counted at 1.0 FTE for all 5 years.
This provision is effective for residency training years beginning on or after July 1, 2000 to residency programs that began before, on, or after November 29, 1999. Conforming changes to the regulations will follow.

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

**This Program Memorandum may be discarded after September 30, 2000.**

**Contact person: Stephen Phillips at 410-786-4531.**

***Implementation Date*: Provision Specific (see above).**

***Effective Date***: **Provision Specific (see above).**