

FY 2005 Prospective Payment System Payment Impact File (May 2004 Update):

This file contains data used to estimate FY 2005 payments under Medicare's prospective payment systems (PPS) for hospitals' operating and capital costs. The data are taken from various sources, including the Provider Specific File, the PPS-XV and PPS-XVI cost report Minimum Data Sets, and prior years' impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to PPS published in the Federal Register. This file is available for release after the PPS Proposed and Final Rules are published in the Federal Register, which generally occurs during May (Proposed) and August (Final).

**FY 2005 PPS PROPOSED PAYMENT IMPACT FILE**

<u>File Pos.</u>	<u>Format</u>	<u>Title</u>	<u>Description</u>
1	\$6.	Provider Number	Six character provider number, first two digits identify the State <sup>1</sup>
8	\$40.	Hospital Name	From cost reports
49	4.	Average Daily Census (ADC)	From cost reports
54	4.	Number of Beds	From cost reports
59	8.2	Medicare Discharges	From 2003 MEDPAR file (adjusted for transfer cases) <sup>2,3</sup>
68	6.4	Case-Mix Index	Version 22 GROUPER (adjusted for transfer cases) <sup>4</sup>
75	6.4	Operating Cost of Living Adjustment	Applied to providers in Alaska and Hawaii for operating PPS
82	6.4	Capital Cost of Living Adjustment	Applied to providers in Alaska and Hawaii for capital PPS
89	9.7	Capital Outlier Percentage	Estimated capital outlier payments as a percentage of Federal capital PPS payments
99	7.5	Capital Cost-to-Charge Ratio	From Provider Specific File, ratio of Medicare capital costs to Medicare covered charges
107	9.7	Disproportionate Share (DSH) Patient Percentage	As determined from cost report and Social Security Administration (SSA) data
117	9.7	Capital DSH Adjustment Factor	Applied to Federal PPS payments

127	9.7	Operating DSH Adjustment Factor	Applied to operating PPS payments
137	\$4.	New Pre-Reclassification Metropolitan Statistical Area (MSA)	New MSA PRN based on the new CBSA definitions - MSA where hospital is actually located, prior to any reclassification decisions by the Medicare Geographic Classification Review Board (MGCRB). Rural areas designated by two digit SSA State codes. <sup>4</sup>
142	\$4.	Post-Reclassification FY 2005 MSA (Wage Index)	MSA used for wage index assignment after reclassification by the MGCRB.
147	\$4.	Post-Reclassification FY 2005 MSA (Standardized Payment Amount)	MSA used for standardized amount assignment after reclassification by the MGCRB.
152	7.5	Operating Cost-to-Charge Ratio	From Provider Specific File, ratio of Medicare operating costs to Medicare covered charges
160	9.7	Operating Outlier Percentage	Estimated operating outlier payments as a percentage of operating PPS payments
170	2.	Provider Type	<p>0 = Short term PPS hospital</p> <p>7 = Rural Referral Center</p> <p>8 = Indian hospital</p> <p>14 = Medicare-Dependent, Small Rural Hospital</p>

- 16 = Sole Community Hospital
- 17 = Sole Community Hospital and Rural Referral Center
- 21 = Essential Access Community Hospital
- 22 = Essential Access Community Hospital/Rural Referral Center

173	7.5	Resident-to-ADC ratio	Used to calculate the indirect medical education (IME) adjustment for capital PPS payments
181	\$1.	Reclassification Status	<p>Indicates hospitals reclassified by the MGCRB</p> <p>N = Not reclassified</p> <p>R = Reclassified for the standardized payment amount</p> <p>W = Reclassified for the wage index</p> <p>B = Reclassified for the standardized payment amount and the wage index</p> <p>L = Reclassified under Section 1886(d)(8) of the Social Security Act</p>
183	2.	Census Division	Based on pre-reclassification MSA assignment

- 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
- 40 = Puerto Rico

186	6.4	Resident-to-Bed Ratio	Used to determine IME factor for operating PPS payments
193	9.7	Capital IME Adjustment	Based on resident-to-ADC ratio
203	9.7	Operating IME Adjustment	Based on resident-to-bed ratio
213	\$6.	Pre-Reclassification Urban/Rural Location	Urban/rural designations based on geographic location prior to reclassification by the MGCRB  LURBAN = Large urban area  OURBAN = Other urban area  RURAL = Rural area
220	\$6.	Post-Reclassification Urban/Rural Location	Urban/rural designations after reclassification by the MGCRB (see pre-reclass

			urban/rural location for key)
227	6.4	Medicare Utilization Rate	Medicare days as a percentage of total inpatient days. (Data not available for all hospitals)
234	9.7	Capital Wage Index	Used to determine geographic adjustment factor
244	9.7	Operating Wage Index	Applied to labor-share of standardized amount
254	9.7	Operating Wage Index with 508 provision of the MMA	Applied to labor-share of standardized amount taking into account providers that fall within section 508 of the MMA
264	9.7	Final Operating Wage Index	Applied to labor-share of standardized amount, taking into account providers' having one of the following wage values: post-reclassification, section 508 or section 505 of the MMA
274	9.7	Puerto Rico Operating Wage Index	Used to adjust the labor portion of the Puerto Rico operating standardized amount.
284	8.2	Old Hospital Specific Rate	Old Hospital Specific Rate updated to FY 2005 82 or 87 Hospital Specific Rate updated to FY 2005(Data for Sole Community Hospitals).
293	8.2	Hospital-Specific Rate	The greater of the 1996 hospital specific rates or the current federal rate (50%)(Data for Sole Community Hospitals).

302	§4.	State County Code	County in which hospital is physically located.
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**Notes:**

<sup>1</sup> SSA State Codes:

01	ALABAMA	44	TENNESSEE
02	ALASKA	45	TEXAS
03	ARIZONA	46	UTAH
04	ARKANSAS	47	VERMONT
05	CALIFORNIA	49	VIRGINIA
06	COLORADO	50	WASHINGTON
07	CONNECTICUT	51	WEST VIRGINIA
08	DELAWARE	52	WISCONSIN
09	DISTRICT OF COLUMBIA	53	WYOMING
10	FLORIDA		
11	GEORGIA		
12	HAWAII		
13	IDAHO		
14	ILLINOIS		
15	INDIANA		
16	IOWA		
17	KANSAS		
18	KENTUCKY		
19	LOUISIANA		
20	MAINE		
21	MARYLAND		
22	MASSACHUSETTS		
23	MICHIGAN		
24	MINNESOTA		
25	MISSISSIPPI		
26	MISSOURI		
27	MONTANA		
28	NEBRASKA		
29	NEVADA		
30	NEW HAMPSHIRE		
31	NEW JERSEY		
32	NEW MEXICO		
33	NEW YORK		
34	NORTH CAROLINA		
35	NORTH DAKOTA		
36	OHIO		
37	OKLAHOMA		
38	OREGON		
39	PENNSYLVANIA		
40	PUERTO RICO		
41	RHODE ISLAND		
42	SOUTH CAROLINA		
43	SOUTH DAKOTA		

2 Medicare discharges are adjusted to account for the less-than-full (per diem) payment hospitals receive for cases transferred to another PPS hospital prior to reaching the geometric mean length of stay for the DRG. The adjustment is calculated by accounting for transfers in proportion to the total per diem payment relative to the full DRG amount, calculated as:  $1 \times (\text{Length of stay prior to transfer plus one day}) / \text{Geometric Mean LOS}$ , where the result cannot exceed 1.

3 In addition to transfers from one PPS hospital to another, Medicare discharges are adjusted to account for the implementation of section 4407 of the Balanced Budget Act, which required Medicare to pay as transfers discharges from 29 DRGs to postacute care. In this year's update, we proposed to expand the postacute care transfer policy to an additional 3 DRGs and dropped one DRG from the existing policy that applies to 29 DRGs. This results in a total of 32 DRGs that are affected by this policy. In the case of twenty-six (26) of these DRGs (12, 14, 24, 25, 88, 89, 90, 113, 121, 122, 127, 130, 131, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 430, 468, 483, 541 and 542), transfers to postacute care are paid using the same methodology as transfers from one PPS hospital to another. For three DRGs (209, 210, and 211), payment is equal to half of what the case would get under the PPS to PPS transfer methodology plus the per diem amount, and half of the per diem amount for each additional day of the patient stay, up to the full DRG amount.

4 The case-mix index is also adjusted to account for transfers occurring before the geometric mean length of stay. This adjustment is calculated as:  $\text{Sum of (DRG Relative Weight} \times (\text{Transfer Payment Amount} / \text{Full DRG Payment Amount}))$ . Transfer adjusted number of Medicare discharges.