

## AAMC Summary and Analysis

### Federal Fiscal Year 2001 Medicare Inpatient PPS Final Rule: Provisions of Interest to Teaching Hospitals

On August 1, 2000, the Health Care Financing Administration (HCFA) published its final rule containing changes to the Medicare hospital inpatient prospective payment system (PPS) and the PPS payment update for Federal fiscal year (FY) 2001. See *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates; Final Rule*. 65 Fed. Reg. 47054. These changes were initially published as a proposed rule on May 5, 2000. See 65 Fed. Reg. 26282.

According to the final rule's fiscal impact analysis of the Medicare changes for FY 2001, on average, all hospitals will gain about 1.5 percent in operating payments per case. Teaching hospitals with 100 or more residents will gain 1.6 percent, other teaching hospitals will gain 1.4 percent, and nonteaching hospitals will gain 1.6 percent. 65 Fed. Reg. at 47191.

#### I. Inpatient PPS Operating Payment Rate Update

The final rule implements the requirement in the Balanced Budget Act of 1997 (BBA) that the hospital operating PPS standardized payment rate be increased in FY 2001 by the increase in the hospital market basket (MB) less 1.1 percentage points. According to the final rule, the most recent forecast of the MB increase for FY 2000 is 3.4 percent. Thus, the update factor will be **2.3 percent**.

The specific standardized amounts will be:

Area	Labor-related Stand. Amt	Non-Labor-Related
Large Urban	\$2,864.19	\$1,164.21
Other Areas	\$2,828.85	\$1,145.78

*Analysis:* If Medicare relief legislation is passed, it is possible that the standardized amounts will be higher than reflected in the final rule. The AAMC, along with other hospital associations, is advocating that the standardized amounts be updated by the full increase in the hospital market basket in FY 2001.

#### II. Changes to Direct Graduate Medical Education (DGME) Payments

##### A. Overview

The final rule sets forth the methodology for implementing the changes to DGME payments that were mandated by the Balanced Budget Refinement Act of 1999 (BBRA).<sup>1</sup> The changes will affect hospitals' DGME payments for Medicare cost reporting periods

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<sup>1</sup> A complete discussion of this methodology is contained in pages 47090-47093 of the August 1 final rule.

beginning on or after October 1, 2000 (FY 2001) through those that begin on or before September 30, 2005 (FY 2005).

The new methodology centers around a national average per resident amount (PRA), and the calculation of a 70 percent “floor” PRA and a 140 percent “ceiling” PRA. The floors and ceilings will vary by geographic area, because the national average per resident amount will be adjusted by the geographic adjustment factor that is used under the Medicare physician fee schedule (“locality adjustment”). Each hospital’s PRA(s) will be compared to its corresponding area floor and ceiling amounts to determine whether its DGME payments will be adjusted. Hospitals with PRAs below the 70 percent floor will have their PRA replaced by the floor amount. Hospitals with PRAs above the 140 percent ceiling will have their DGME payments frozen for two years and then have reduced inflation updates for three subsequent years. Hospitals with PRAs between the floor and ceiling amounts will be unaffected by the new methodology.

*Analysis*— The final rule follows closely the language of the BBRA, which was quite prescriptive in setting forth the methodology for determining the national average and floor and ceiling PRA amounts. The methodology does not differ from what was contained in the May 5 proposed rule.

It is important to remember that each teaching hospital has two different PRAs--one for primary care residents and one for non-primary care residents.<sup>2</sup> The national average and floor and ceiling amounts reflect a combined primary care/non-primary care amount. Consequently, hospitals will compare each PRA to the floor and ceiling amounts to determine whether one or both PRAs will be affected.

## **B. Calculation of a Locality-Adjusted National Average Per Resident Amount**

The locality-adjusted national average PRA will be based on data from hospital cost reports ending in FY 1997. The national average reflects both primary care and non-primary care PRAs and is weighted by the number of residents at each hospital (that is, PRAs for hospitals with large numbers of residents will contribute more to the national average than hospitals with small numbers of residents). According to HCFA’s calculations, the weighted national average PRA for cost reporting periods ending in FY 1997 is **\$68,464**.<sup>3</sup> (This amount differs slightly from what HCFA published in the proposed rule.)

The 1997 national average PRA is then updated to FY 2001 to reflect inflation. The updated amount, however, may be different for each hospital, depending on its cost reporting period. According to the final rule, the 1997 amount will be updated by the estimated percentage increase in the consumer price index for all urban consumers (CPI-U) for the period that begins with the month which represents the midpoint of the cost

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<sup>2</sup> The two amounts resulted when PRAs for nonprimary care residents were not updated in FYs 1994 and 1995, as required by law.

<sup>3</sup> Note that the level of the PRA corresponds to total resident costs, *not* total Medicare DGME payments. Medicare pays only a portion of a hospital’s PRA, depending on its share of Medicare patient days.

reporting periods for *all hospitals* (which is October 1, 1996) and ends with the month which represents the midpoint of *each individual hospital's* cost reporting period that begins during FY 2001.

Finally, to reflect differences in labor costs across areas, the 2001 national average PRA will be multiplied by the 1999 geographic adjustment factor (GAF)<sup>4</sup> for the physician fee schedule area where the hospital is located, to arrive at a locality-adjusted weighted national average PRA for each hospital.

*Analysis*—Because of the requirement that the 1997 national average PRA be updated to the midpoint of each hospital's cost reporting period in FY 2001, each cost reporting cycle will have its own national average PRA.

Appendix 1 contains a list of the weighted national average PRAs for each cost reporting period. Note that the values in Appendix 1 are based on *projections* of the CPI-U increases. According to HCFA staff, these numbers will be subject to revision to reflect actual changes in the CPI-U, when that information becomes available.

As indicated in the final rule, the national average PRAs will also be adjusted by the 1999 GAF for the Medicare physician fee schedule area in which the hospital is located. These values are set forth in Addendum F of the October 31, 1997 physician fee schedule final rule (62 Fed. Reg. at 59257) and published in Appendix 2 to this document.

### **C. Calculation of “Floor” and “Ceiling” PRAs**

The “floor” PRA is calculated by multiplying each hospital's locality-adjusted national average PRA by 70 percent. The “ceiling” is equal to the locality-adjusted national average multiplied by 140 percent.

### **D. Impact of Floor and Ceiling on Individual Hospitals' PRAs**

#### **1. Hospitals with PRAs below the 70 percent floor**

For cost reporting periods beginning in FY 2001, hospitals with PRAs (either primary care or non-primary care, or both) that are below the 70 percent floor will have those amounts replaced by the floor amount. The new PRA will then be updated in future years by the increase in the CPI-U. If both primary care and non-primary care amounts are below the floor levels, the same floor level amount will be used to determine DGME payments for both primary care and non-primary care residents.

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<sup>4</sup> The GAF is an average of the three geographic index values used to adjust physician payments for different wage areas.

## 2. Hospitals with PRAs above the 140 percent ceiling

The determination of whether the 140 percent ceiling will affect a hospital's PRA will differ depending upon the fiscal year:

*FY 2001*—For cost reporting periods beginning in federal FY 2001 (October 1, 2000 through September 30, 2001), if the hospital's **FY 2000** PRA exceeds 140 percent of the **FY 2001** locality-adjusted national average PRA, the hospital's FY 2001 PRA is frozen at the FY 2000 PRA and is not updated by the CPI-U factor for FY 2001.

*FY 2002*—For cost reporting periods beginning in FY 2002 (October 1, 2001 through September 30, 2002), if the hospital's **FY 2001** PRA exceeds 140 percent of the **FY 2002** locality-adjusted national average PRA, the hospital's PRA is frozen at the FY 2001 PRA and is not updated by the CPI-U factor for FY 2002.

*FYs 2003 through 2005*—For cost-reporting periods beginning in FYs 2003, 2004, and 2005, if the hospitals' PRA for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for the **same** previous cost reporting period, the hospital's PRA will be updated by the increase in the CPI-U for the current year less two percentage points (although the update cannot be less than zero).

## 3. Hospitals with PRAs greater than or equal to the 70 percent floor or less than or equal to the 140 percent ceiling

Hospitals with PRAs that are greater than or equal to the 70 percent floor or less than or equal to the 140 percent ceiling are unaffected by the new methodology. For FY 2001 cost-reporting periods and beyond, these hospitals' PRAs will continue to be updated by the increase in CPI-U, as set forth under 42 C.F.R. §413.86(e)(3)(i).

## 4. General rule for hospitals with PRAs that exceed the ceiling amounts

If a hospital's PRA exceeds the ceiling and would otherwise be adjusted according to the regulations, in any given current year (FY 2001 through FY 2005), its PRA will not be reduced below the ceiling amount.

*Analysis*—It is important that hospitals with PRAs that are close to the floor and ceiling amounts review the final rule and accompanying preamble to better understand the new methodology and potential implications on DGME payments.

### **III. IME Changes**

The final rule changes the IME adjustment factor to implement the BBRA requirement that the IME adjustment for FY 2001 be equal to a 6.25 percentage add-on.

*Analysis*—The BBA had mandated that the IME adjustment in FY 2001 be set such that the IME percentage add-on would equal 5.5 percent. The BBRA increased this to the 6.25 percent level. The AAMC is seeking legislation to maintain IME payments at current levels. Two bills have been introduced, HR 4239 and S. 2394, to maintain Medicare IME payments at the FY 2000 level of 6.5 percent for the foreseeable future.

#### **IV. DSH Changes**

The final rule implements the BBRA requirement to reduce the Medicare DSH payment that a hospital would otherwise receive in FY 2001 by 3 percent, and by 4 percent in FY 2002.

*Analysis*—The BBRA provisions result in less DSH payment reductions than originally set forth in the BBA. Under the BBA, DSH payments would have been reduced by 4 percent in FY 2001 and 5 percent in FY 2002. Under both the BBA and BBRA, no reductions will occur in FYs 2003 and beyond.

#### **V. Changes to the Hospital Wage Index**

For FY 2001, the Medicare hospital wage index will be based on data submitted by hospitals for cost reporting periods that began in FY 1997. The wage index will also reflect the second year of a five-year phase-out of costs related to teaching physicians, residents, and certified registered nurse anesthetists (CRNAs); other physician costs, such as those associated with hospital administrative functions, will be retained in the wage index calculation. For FY 2001, the wage index will be based on a blend of 60 percent of an average hourly wage including the teaching physician, resident, and CRNA costs, and 40 percent of an average hourly wage excluding these costs.

The FY 1997 cost reports, which supply the data for the 2001 wage index, do not distinguish between physician costs that are associated with teaching and those costs associated with hospital administrative functions. Accordingly, HCFA conducted a survey to determine what proportion of total physician costs were associated with teaching activities. For those hospitals that responded to the survey, their wage data were modified to obtain a value that excludes the reported teaching physician costs. However, if teaching hospitals did not complete the survey, and HCFA verifies that the hospitals has otherwise unidentified teaching physician costs, HCFA removed 100 percent of the reported physician costs, on the presumption that all of the costs are associated with teaching functions.

*Analysis*—HCFA's proposal to remove 100 percent of the teaching physician costs differs from last year, when HCFA chose to remove 80 percent of the total physician costs, on the assumption that 20 percent of the costs were associated with administrative functions. HCFA revised the FY 1998 Medicare cost reports such that hospitals reported teaching physician Part A costs separately. Consequently, after this year, a separate survey to identify these costs will not be necessary.

## **VI. Increase in the Outlier Payment Threshold**

The final rule increases the fixed loss cost threshold for outlier payments to be equal to a case's diagnosis-related group (DRG) payment plus any IME and DSH payments, plus \$17,550. In FY 2000, the threshold was the DRG payment plus any IME and DSH payments, plus \$14,050. As in past years, hospitals will receive 80 percent of the costs that exceed the threshold levels.

*Analysis*—The FY 2001 cost threshold is significantly higher than in FY 2000, which had represented a significant increase over the FY 1999 level. A primary reason for the increase is due to higher than expected outlier payments made in recent years. Outlier payments are funded through a 5.1 percent reduction in the PPS standardized payment amount. Consequently, HCFA sets the outlier cost threshold at a level that it believes will result in outlier payments that equal 5.1 percent of total DRG payments. However, HCFA estimates that outlier payments represented 7.5 percent of total payments in FY 1999, and 6.1 percent for FY 2000.

## **VII. No Distinct DRG for Joint Pancreas/Kidney Transplants**

Currently, patients who receive dual kidney-pancreas transplants are assigned to the same DRG as those patients receiving only a kidney transplant (DRG 302—Kidney Transplant). In the final rule, HCFA rejected comments urging that a distinct DRG be created for the dual transplants.

*Analysis*—In our comment letter, the AAMC had urged HCFA to re-evaluate its decision not to create a new DRG for dual transplants. In the final rule preamble, HCFA indicated that it will continue to monitor the costs associated with dual transplants to determine if, at some point, a new DRG is warranted.

APPENDIX 1

**Projected Updated National Average Per Resident Amounts for Cost Reporting Periods Beginning in FY2001, Using the CPI (U) - All Items**

(1)	(2)	(3)	(4)	(5)	(6)
National Average PRA for All Cost Reporting Periods Ending in FY 1997*:	Midpoint of All Cost Report Periods Ending in FY 1997:	Cost Reports Beginning in:	Midpoint of Cost Report Period:	Projected Update Factor for Midpoint of Cost Report Period**:	Projected Updated National Average PRA (Col. 1 x Col. 5)
\$68,464	October 1, 1996	October 1, 2000	April 1, 2001	1.10509	\$75,659
\$68,464	October 1, 1996	November 1, 2000	May 1, 2001	1.10653	\$75,757
\$68,464	October 1, 1996	December 1, 2000	June 1, 2001	1.10796	\$75,855
\$68,464	October 1, 1996	January 1, 2001	July 1, 2001	1.11006	\$75,999
\$68,464	October 1, 1996	February 1, 2001	August 1, 2001	1.11282	\$76,188
\$68,464	October 1, 1996	March 1, 2001	September 1, 2001	1.11559	\$76,378
\$68,464	October 1, 1996	April 1, 2001	October 1, 2001	1.11723	\$76,490
\$68,464	October 1, 1996	May 1, 2001	November 1, 2001	1.11774	\$76,525
\$68,464	October 1, 1996	June 1, 2001	December 1, 2001	1.11826	\$76,561
\$68,464	October 1, 1996	July 1, 2001	January 1, 2002	1.12028	\$76,699
\$68,464	October 1, 1996	August 1, 2001	February 1, 2002	1.12382	\$76,941
\$68,464	October 1, 1996	September 1, 2001	March 1, 2002	1.12737	\$77,184

\*Weighted national average per resident amount for cost reporting periods ending during FY 1997 as estimated by the Health Care Financing Administration in the Medicare PPS 2001 final rule

(65 Fed. Reg. at 47091).

\*\*Update projections provided by HCFA. Note, the official PRA values will be determined by the actual increase in the CPI-U.

1999 Medicare Physician Fee Schedule  
Geographic Adjustment Factors  
(Source: 1998 Physician Fee Schedule Final Rule, October 31, 1997)

Carrier No.	Locality No.	Locality name	1999 GAF
00973	50	VIRGIN ISLANDS .....	0.997
00621	16	CHICAGO, IL .....	1.084
00901	99	REST OF MARYLAND .....	0.980
00621	12	EAST ST. LOUIS, IL .....	0.989
00528	99	REST OF LOUISIANA .....	0.936
00621	99	REST OF ILLINOIS .....	0.933
00528	01	NEW ORLEANS, LA .....	0.986
00820	01	NORTH DAKOTA .....	0.906
00803	02	NYC SUBURBS/LONG I., NY .....	1.177
00834	00	NEVADA .....	1.016
00803	03	POUGHKPSIE/N NYC SUBURBS, NY .....	1.056
00835	01	PORTLAND, OR .....	0.987
00820	02	SOUTH DAKOTA .....	0.886
00900	31	AUSTIN, TX .....	0.985
16510	16	WEST VIRGINIA .....	0.925
00824	01	COLORADO .....	0.971
00900	99	REST OF TEXAS .....	0.929
00910	09	UTAH .....	0.931
00836	99	REST OF WASHINGTON .....	0.968
31144	40	NEW HAMPSHIRE .....	1.008
00511	01	ATLANTA, GA .....	1.015
00511	99	REST OF GEORGIA .....	0.940
05535	00	NORTH CAROLINA .....	0.928
14330	04	QUEENS, NY .....	1.167
00900	11	DALLAS, TX .....	1.009
00751	01	MONTANA .....	0.910
00831	01	ALASKA .....	1.131
05130	00	IDAHO .....	0.913
00630	00	INDIANA .....	0.927
00660	00	KENTUCKY .....	0.923
00803	01	MANHATTAN, NY .....	1.227
00900	09	BRAZORIA, TX .....	1.005
10490	00	VIRGINIA .....	0.946
31145	50	VERMONT .....	0.957
02050	18	LOS ANGELES .....	1.104
10250	00	MISSISSIPPI .....	0.900
00835	99	REST OF OREGON .....	0.934
05440	35	TENNESSEE .....	0.924
00590	03	FORT WORTH, TX .....	0.978
00570	01	DELAWARE .....	1.015
00640	00	IOWA .....	0.912
00623	99	REST OF MICHIGAN .....	1.013
00655	00	NEBRASKA .....	0.894
16360	00	OHIO .....	0.973
00973	20	PUERTO RICO .....	0.794
00900	18	HOUSTON, TX .....	1.034
00900	20	BEAUMONT, TX .....	0.973
00836	02	SEATTLE (KING CNTY), WA .....	1.023
00825	21	WYOMING .....	0.925
02050	99	REST OF CALIFORNIA* .....	1.007
31140	99	REST OF CALIFORNIA* .....	1.007
00520	13	ARKANSAS .....	0.886
00832	00	ARIZONA .....	0.994
00740	02	METROPOLITAN KANSAS CITY, MO .....	0.982
11260	01	METROPOLITAN ST. LOUIS, MO .....	0.983
00801	99	REST OF NEW YORK .....	0.973
00901	01	BALTIMORE/SURR. CNTYS, MD .....	1.031
00900	15	GALVESTON, TX .....	1.000
00510	00	ALABAMA .....	0.930
02050	26	ANAHEIM/SANTA ANA, CA .....	1.090
00621	15	SUBURBAN CHICAGO, IL .....	1.048
00521	05	NEW MEXICO .....	0.935
00522	00	OKLAHOMA .....	0.908
00880	01	SOUTH CAROLINA .....	0.913
00590	99	REST OF FLORIDA .....	0.981
31142	99	REST OF MAINE .....	0.934
00740	99	REST OF MISSOURI* .....	0.908
11260	99	REST OF MISSOURI* .....	0.908
00865	99	REST OF PENNSYLVANIA .....	0.948
10240	00	MINNESOTA .....	0.957
31140	03	MARIN/NAPA/SOLANO, CA .....	1.058
31142	03	SOUTHERN MAINE .....	0.987
31140	07	OAKLAND/BERKLEY, CA .....	1.086
10230	00	CONNECTICUT .....	1.100
00623	01	DETROIT, MI .....	1.131

1999 Medicare Physician Fee Schedule  
 Geographic Adjustment Factors  
 (Source: 1998 Physician Fee Schedule Final Rule, October 31, 1997)  
 Continued

Carrier No.	Locality No.	Locality name	1998 GAF
00860	99	REST OF NEW JERSEY .....	1.044
00865	01	METROPOLITAN PHILADELPHIA, PA .....	1.059
31140	06	SAN MATEO, CA .....	1.122
00900	28	FORT LAUDERDALE, FL .....	1.046
31140	09	SANTA CLARA, CA .....	1.125
00590	04	MIAMI, FL .....	1.105
31140	05	SAN FRANCISCO, CA .....	1.143
00580	01	DC +MDVA SUBURBS .....	1.095
31143	99	REST OF MASSACHUSETTS .....	1.030
00860	01	NORTHERN NJ .....	1.099
00650	00	KANSAS* .....	0.933
00740	04	KANSAS* .....	0.933
00951	00	WISCONSIN .....	0.955
00833	01	HAWAII/GUAM .....	1.072
31143	01	METROPOLITAN BOSTON .....	1.088
00870	01	RHODE ISLAND .....	1.047
02050	17	VENTURA, CA .....	1.055

\* Payment locality is serviced by two carriers.