OMFS Update for Inpatient Hospital Services (Effective for discharges occurring on or after March 1, 2011)

1. Data Sources
    a. The Medicare FY11 update to the inpatient prospective payment system was published on August 16, 2010 in the Federal Register (Vol. 75 FR 50042) and is entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services" (CMS-1498-F). A correction to the final rule was published on October 1, 2010, in the Federal Register (Vol. 75 FR 60640), and is entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY 2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services; Corrections" (CMS-1498-F). These documents are available at http://www.cms.hhs.gov/AcuteInpatientPPS/.

    b. The factors to determine composite rates are available on the CMS website at http://www.cms.hhs.gov/AcuteInpatientPPS/. The public use file used to calculate the composite rates is entitled "FY 2011 Final Rule – IPPS Impact File. The file contains wage data posted on the CMS website as of September 2010.

2. Composite Rate Calculation

    a. Update to the standardized amount. L.C. 5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for inpatient hospital facility fees shall be determined solely by the estimated increase in the hospital market basket. Thus, in lieu of using the Medicare FY2011 rates to determine the updated OMFS amounts, the estimated increase in the hospital market basket was applied to the FY2010 OMFS rates.

    b. OMFS rate for operating costs
        i. Based on the Medicare Hospital Inpatient Prospective Payment System, all hospitals are paid the same standard rate for operating costs (based on the rate for hospitals located in large urban areas). The FY2010 rate was $ 5,354.08. The estimated increase in the market basket is 2.6%. The FY2011 standard rate under the OMFS is
        $ 5,493.28 ($ 5,354.08 x 1.026).

ii. The Medicare Hospital Inpatient Prospective Payment System provides that if a hospital's wage index is less than or equal to 1.0, the labor-related share is .62 of the standard rate. If the wage index is greater than 1.0, the labor-related share is .688. The wage-adjusted standard rate is determined as follows:
    a. For discharges occurring on or after March 1, 2011, use FY 2011 wage index, which can be found in the Impact File for FY 2011
    b. If FY 2011 wage index >1.0, wage-adjusted rate =$5,493.28 x (.688 x FY 2011 wage index + .312)
    c. If FY 2011 wage index <=1.0, wage-adjusted rate =$5,493.28 x (.62 x FY 2011 wage index + .38)

iii. The wage-adjusted operating rate is further adjusted for any additional payments for teaching and serving a disproportionate share of low-income patients.
Adjusted operating rate = wage-adjusted standard rate x (1 + DSHOPG + TCHOP)

c. OMFS rate for capital-related costs
    i. The estimated increase in the capital market basket is 1.2%. The FY2011 capital standard federal payment rate is $446.75 ($441.46 x 1.012).
    ii. The capital standard federal payment rate is adjusted for the capital geographic adjustment factor, teaching, and for serving low-income patients.
    iii. For discharges occurring on or after March 1, 2011, use FY 2011 GAF, which can be found in the Impact file for FY 2011:
        1. Adjusted capital standard federal payment rate = $446.75 x FY 2011 GAF x (1+ DSHCPG + TCHCP).

d. The standard composite rate is the sum of the OMFS rate for operating costs and the OMFS rate for capital-related costs.

e. Sole community hospitals (PTYPE = 16 or 17) receive the higher of the standard composite rate or a composite rate based on a hospital-specific rate for operating costs plus the OMFS rate for capital-related costs. When the hospital-specific composite rate (FY 11HSP rate) is higher than the standard composite rate, the amount is shown in italics. The FY 11 HSP rate is the FY 1982/1987/1996/2006 Hospital Specific Payment (HSP) Rate updated to FY 2011 for SCH providers.

3. Cost-to-charge ratio (CCR) used to determine outlier payments is the sum of the operating and capital cost-to-charge ratios. CCR = Operating CCR + Capital CCR

4. Hospital-specific outlier factor

a. The fixed loss cost outlier threshold is $ 23,075.
b. The fixed loss cost outlier threshold is allocated to operating and capital components and adjusted for geographic location as follows:
    i. For discharges occurring on or after March 1, 2011, use FY 2011 wage index, which can be found in the Impact File for FY 2011:
        1. If FY 2011 wage index > 1.0, operating outlier factor = $23,075 x Operating CCR/CCR x (FY 2011 wage index x .688+ . 312)
        2. If FY 2011 wage index < =1.0, operating outlier factor = $23,075 x Operating CCR/CCR x (FY 2011 wage index x .62 + .38)
    ii. For discharges occurring on or after March 1, 2011, use FY 2011 GAF, which can be found in the Impact File for FY 2011:
        1. Capital outlier factor = $23,075 x Capital CCR/CCR x FY 2011 GAF
    iii. Hospital-specific outlier factor = operating outlier factor + capital outlier factor

5. DRG Relative Weights: Revised DRG relative weights were published on August 16, 2010 in the Federal Register (Vol. 75 FR 50042 at page 50547) as "TABLE 5--List Of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay – FY 2011". Section 9789.24, Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay is revised to reflect these changes effective with discharges occurring on or after March 1, 2011.

6. Maximum Allowable Fees: To determine the standard payment rate, the hospital-specific composite rate would be multiplied by the DRG relative weight and 1.20 multiplier. Additional payments will be made for high cost outlier cases and for certain pass-through costs in accordance with the regulations.

7. Acute Care Transfers: Section 9789.22(i)(2)(A) is amended to conform to Medicare's updates to the qualifying Medicare Severity DRGs when an acute care patient is discharged to a post-acute care provider, which were published on August 16, 2010 in the Federal Register (Vol. 75 FR 50042; CMS-1406-F). This document is available at http://www.cms.hhs.gov/AcuteInpatientPPS/. Table 5 lists how the transfer policy will apply when an acute care patient in a particular MS-DRG is discharged to a post-acute care provider.

8. Section 9789.22(i)(2)(B) is amended to conform to Medicare's updates to Medicare-Severity DRGs subject to payment under this subsection which are indicated with a "yes", in the "FY2011 Final Rule Special Pay DRG" column, listed in Table 5, which was published on August 16, 2010 in the Federal Register (Vol. 75 FR 50042; CMS-1406-F). This document is available at http://www.cms.hhs.gov/AcuteInpatientPPS/.

9. Sections 9789.20 through 9789.24 are further amended by Order of the Acting Administrative Director as described in paragraph 10, below. In particular, the subsections which reference the Federal Register or Code of Federal Regulations are amended to incorporate by reference the Federal Register, August 16, 2010 in the Federal Register (Vol. 75 FR 50042) and is entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services" (CMS-1498-F), and the correction to the final rule published on October 1, 2010, in the Federal Register (Vol. 75 FR 60640), and is entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY 2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services; Corrections" (CMS-1498-F), to be applied to discharges occurring on or after March 1, 2011.

10. Pursuant to Labor Code section 5307.1(g)(2), the Acting Administrative Director of the Division of Workers' Compensation orders that to the extent references to the Federal Register or Code of Federal Regulations are made in any sections starting from section 9789.20 through 9789.24 of Title 8 of the California Code of Regulations, said section is hereby amended to incorporate by reference the applicable Federal Register final rule (including correction notices and revisions) and Federal Regulations in effect as of the date the Order becomes effective, to be applied to discharges occurring on or after March 1, 2011.