OMFS Update for Inpatient Hospital Services (Effective for discharges occurring on or after July 15, 2005)

1. Data Sources

    a. The Medicare FY05 update to the inpatient prospective payment system was published on August 11, 2004 in the Federal Register (Vol. 69 FR 48916) and is entitled " Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates" (CMS-1428-F). A correction to the final rule was published on October 7, 2004 in the Federal Register (Vol. 69 FR 60242), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Correction of Final Rule" (CMS-1428-cn2). A correction to the final rule and the October 7, 2004 correction was published on December 30, 2004 in Federal Register (Vol. 69FR 78526), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Correcting Amendment; Final Rule" (CMS-1428-F2). These documents are available at http://www.cms.hhs.gov/providers/hipps/.

    b. The factors to determine composite rate are available on the CMS website at http://www.cms.hhs.gov/providers/hipps/hist_impact_94-04.asp The public use file is entitled "FY 2005 Final Impact (as of Dec. 30, 2004)." The file contains corrected wage data posted on the CMS website as of December 30, 2004.

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 FY05 rates to determine the updated OMFS amounts, the estimated increase in the hospital market basket was applied to the FY04 rates.

    b. OMFS rate for operating costs
        i. Based on a provision of the Medicare Modernization Act (MMA), all hospitals are paid the same standard rate for operating costs (based on the rate for hospitals located in large urban areas). The FY04 rate was $ 4,423.84. The estimated increase in the market basket is 3.3%. The FY05 standard rate under the OMFS is $ 4,569.83 ($4,423.84 x 1.033).
        ii. The MMA provides that if a hospital's wage index is less than 1.0, the labor-related share is .62 of the standard rate. If the wage index is 1.0 or higher, the labor-related share is .71066. The wage-adjusted standard rate is determined as follows:

1. If WIGRN>=1.0, wage-adjusted rate =$ 4,569.83 x (.71066 x WIGRN + .28934)
2. If WIGRN<1.0, wage-adjusted rate =$ 4,569.83 x (.62 x WIGRN + .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 + DSHOP + TCHOP)

c. OMFS rate for capital-related costs
   i. Two Medicare rates were in effect during FY04 for capital-related costs because of changes made by the MMA. In its update, CMS uses a simple average of the two rates, which equals $413.83. The Division took the same approach and used the average rate as the starting point. The estimated increase in the capital market basket was 0.7%. The FY05 standard capital rate is $416.73 ($413.83 x 1.007). The standard capital rate is further increased 3% for hospitals located in large urban areas.
   ii. The standard capital is adjusted for the capital geographic adjustment factor, teaching, and for serving low-income patients.
   Adjusted capital rate = $416.73 x WICGRN x (1+ DSHCPG + TCHCPG) [x 1.03 if large urban].

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) 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. The hospital-specific rate for operating costs is the higher of OLDHSPPS or HSP96. When the hospital-specific composite rate is higher than the standard composite rate, the amount is shown in italics.

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

4. Hospital-specific outlier threshold

   a. The standard outlier threshold is $25,800.
   b. The standard outlier threshold is allocated to operating and capital components and adjusted for geographic location as follows:
      i. If WIGRN> 1.0, operating outlier threshold = $25,800 x OPCCR/CCR x (WIGRN x .71066 + .28934)
      ii. If WIGRN< 1.0, operating outlier threshold = $25,800 x OPCCR/CCR x (WIGRN x .62 +.38)

iii. Capital outlier threshold = $25,800 x CPCCR/CCR x WICGRN
iv. Hospital-specific outlier threshold = operating outlier threshold + capital outlier threshold

5. Listing of Hospitals

   a. Hospitals that were certified as critical access hospitals (CAH) as of 9/02 were taken into consideration in the development of this table. Any hospital that has subsequently become a critical access hospital should notify DWC.

   b. Hospitals noted in italics are included in this table, but are not found in the impact file. The composite rate has been determined for these hospitals based on information provided by the hospitals. Any other hospital that does not appear on the Medicare impact file should contact the Division of Workers' Compensation and provide the information needed to determine a composite rate.

6. DRG Relative Weights: Revised DRG relative weights were published on August 11, 2004 in the Federal Register (Vol. 69 FR 48916) as "TABLE 5--LIST OF DIAGNOSIS-RELATED GROUPS (DRGs), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)." 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 July 15, 2005.

7. 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.

8. Acute Care Transfers: Section 9789.22(i)(2)(A) is amended to conform to updates to the qualifying DRGs when an acute care patient is discharged to a post-acute care provider, which was published on August 11, 2004 in the Federal Register (Vol. 69 FR 48916) and is entitled " Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates" (CMS-1428-F), and the correction notice published on October 7, 2004 in the Federal Register (Vol. 69 FR 60242), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Correction of Final Rule" (CMS-1428-cn2). These documents are available at http://www.cms.hhs.gov/providers/hipps/.

9. Pursuant to Labor Code section 5307.1(g)(2), the 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 July 15, 2005.