FY 2000 Prospective Payment System Payment Impact File (August 1999 Update):

This file contains data used to estimate FY 2000 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-XIII and PPS-XIV 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 April (Proposed) and August (Final).

FY 2000 PPS PAYMENT IMPACT FILE

File Pos.	Format	Title	Description
1	$6.	Provider Number	Six character provider number, first two digits identify the State[1]
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 1998 MEDPAR file (adjusted for transfer cases)[2,3]
68	6.4	Case-Mix Index	Version 17 GROUPER (adjusted for transfer cases)[4]
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	8.2	Hospital-Specific Rate	Higher of 1982 or 1987 hospital-

operating PPS payments[137]			specific rates, updated through FY 2000. (Data for Sole Community Hospitals and Medicare-Dependent Small, Rural Hospitals.)
146	$4.	Pre-Reclassification Metropolitan Statistical Area (MSA)	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. [4]
151	$4.	Post-Reclassification FY 2000 MSA (Wage Index)	MSA used for wage index assignment after reclassification by the MGCRB.
156	$4.	Post-Reclassification FY 2000 MSA (Standardized Payment Amount)	MSA used for standardized amount assignment after reclassification by the MGCRB.
161	7.5	Operating Cost-to-Charge Ratio	From Provider Specific File, ratio of Medicare operating costs to Medicare covered charges
169	9.7	Operating Outlier Percentage	Estimated operating outlier payments as a percentage of operating PPS payments
179	2.	Provider Type	0 = Short term PPS hospital 7 = Rural Referral Center 8 = Indian hospital 14 = Medicare-Dependent, Small Rural Hospital

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
182	7.5	Resident-to-ADC ratio	Used to calculate the indirect medical education (IME) adjustment for capital PPS payments
190	$1.	Reclassification Status	Indicates hospitals reclassified by the MGCRB N = Not reclassified R = Reclassified for the standardized payment amount W = Reclassified for the wage index B = Reclassified for the standardized payment amount and the wage index L = Reclassified under Section 1886(d)(8) of the Social Security Act
192	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
195	6.4	Resident-to-Bed Ratio	Used to determine IME factor for operating PPS payments
202	9.7	Capital IME Adjustment	Based on resident-to-ADC ratio
212	9.7	Operating IME Adjustment	Based on resident-to-bed ratio
222	$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
229	$6.	Post-Reclassification Urban/Rural Location	Urban/rural designations after reclassification by the MGCRB (see pre-reclass urban/rural location for key)
236	6.4	Medicare Utilization Rate	Medicare days as a percentage of total inpatient days. (Data not available for all hospitals)
243	9.7	Capital Wage Index	
Used to	9.7	Operating Wage Index	Applied to labor-share of

determine geographic adjustment factor253			standardized amount
263	4.	Mileage to Nearest Hospital	Travel distance, used to determine eligibility for hospital-specific payments for reclassified sole community hospitals.
268	9.7	Puerto Rico Capital Wage Index	Used to adjust the Puerto Rico capital rate.
278	9.7	Puerto Rico Operating Wage Index	Used to adjust the labor portion of the Puerto Rico operating standardized amount.

Notes:

[1] SSA State Codes:

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

[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 X (Length of stay prior to transfer plus one day ÷ 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 requires Medicare to pay as transfers discharges from 10 DRGs to postacute care. In the case of seven of these DRGs (14, 113, 236, 263, 264, 429, and 483), 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, and half of what the case would be paid if it were paid as a normal discharge.

[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:

Sum of (DRG Relative Weight X (Transfer Payment Amount ÷ Full DRG Payment Amount)).
Transfer adjusted number of Medicare discharges.

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