Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2197

SUBJECT: Calculating Provider-Specific Medicare Outpatient Cost-to-Charge Ratios (CCRs) and Instructions on Cost Report Treatment of Hospital Outpatient Services Paid on a Reasonable Cost Basis

This Program Memorandum (PM) provides instructions to intermediaries for calculating provider-specific Medicare outpatient CCRs for hospitals and community mental health centers (CMHCs). CCRs are used in determining outlier payments, payments for pass-through devices and monthly interim transitional corridor payments under the outpatient prospective payment system (OPPS). The PM also provides instructions concerning the hospital cost report treatment of certain outpatient services that continue to be paid on a reasonable cost basis.

I. Cost-to-Charge Ratios

When the OPPS was implemented in August 2000, hospital-specific CCRs were calculated by CMS's central office using the calculation described in PM A-00-63. That PM also provided instructions to intermediaries for calculating CCRs for CMHCs. Since that time, a provider could request a recalculation of its CCR only under limited circumstances.

Intermediaries must now update CCRs to reflect cost and charge information from more recent cost reports for all hospitals and CMHCs that are paid under the OPPS. A provider's intermediary will calculate revised CCRs using the cost report for the provider's most recent full year cost reporting period, whether tentatively settled or final settled. Intermediaries must recalculate the provider's CCR on an ongoing basis whenever a more recent full year cost report is available. If a CCR is calculated based on the provider's tentatively settled cost report, the CCR must be updated when that cost report is final settled or when a cost report for a subsequent cost reporting period is tentatively settled, whichever occurs first. If a CCR is based on a final settled cost report, the CCR must be updated when a cost report for a subsequent cost reporting period is tentatively settled.

A. CCR Calculation for Hospitals

Perform the following calculations using the hospital's most recent full year cost report:

Step 1--Determining Costs: Calculate costs for each cost center by multiplying the departmental cost-to-charge ratio for each cost center (and subscripts thereof) that reflect services subject to the OPPS from CMS Form 2552-96, Worksheet C Part I, column 9 times the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D Part V, columns 2,3,4 and 5 (and subscripts thereof). Sum the costs calculated for each cost center to arrive at Medicare outpatient costs of services subject to OPPS.

Note that charges for services not subject to the OPPS such as physical, occupational and speech therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc. are not to be included in calculating the cost in this step.

Step 2 -- Determining Charges: Calculate charges by summing the Medicare outpatient charges from CMS Form 2552-96, Worksheet D Part V, columns 2,3,4 and 5 (and subscripts thereof) for each cost center (and subscripts thereof) that reflect services subject to the OPPS.

Note that charges for services not subject to the OPPS such as physical, occupational and speech therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc. are not to be included in calculating charges in this step.

Step 3 – Calculating the CCR: Divide the costs from Step 1 by the charges from Step 2 to calculate the hospital's Medicare outpatient CCR.

Generally, the CCRs you calculate are expected to be above 0.110 and below 1.604. If the CCR is greater than 1.604 enter the applicable statewide average urban or rural hospital default ratio that you currently use to determine CCRs for new providers in the provider's outpatient provider specific file [(OPSF) also known as the OPROV specific file]. If the CCR is below 0.110, recheck the calculation to ensure that the CCR is, in fact, a valid CCR for the provider before entering the CCR into the provider's OPSF. Use the CCR you calculate but do not use the statewide average urban or rural hospital as the default ratio in such a circumstance.

B. CCR Calculation for CMHCs

Calculate the CMHC's CCR using the provider's most recent full year cost report, CMS Form 2088-92 and Medicare cost and charges from Worksheet C, page 2. Divide costs from line 39.01, column 3 by charges from line 39.02, column 3 to calculate the CCR.

Generally, the CMHC CCRs you calculate are expected to be below 1.0, if the CCR is above 1.0 enter in the provider's OPSF the applicable statewide average urban or rural hospital default ratio that you currently use to determine CCRs for new providers. There is no lower limit for CMHC CCRs. Therefore, use the CCR you calculate and do not substitute the statewide average urban or rural hospital default ratio in cases where the CCR is below 1.0.

C. Timing of CCR Calculations

Because all provider CCRs must initially be updated as soon as possible, intermediary workload may require prioritization of CCR calculations. Providers that have (1) calculated their own CCR following the calculation described above using their most recent full year cost report and (2) submitted, by no later than January 30, 2003, a copy of their calculations to their intermediary for review and final approval are to be given priority. Revised CCRs for these providers must be reviewed, approved, entered into the OPSF and used to calculate outlier, device pass-through and interim transitional corridor payments not later than 60 days after receipt of the provider's calculation. If you find that the provider's calculation is not correct you are allowed an additional 60 days or until April 30, 2003, whichever date is earlier, to recalculate the CCR and enter the corrected CCR into the OPSF.

Calculations of CCRs for all CMHCs and hospitals subject to the OPPS must be completed and entered into the OPSF not later than April 30, 2003.

D. Application of CCRs

Revised CCRs will be applied prospectively for purposes of calculating outlier payments, device pass-through payments and interim transitional corridor payments [i.e., transitional outpatient payment (TOP) amounts]. In addition, for providers that calculate their revised CCRs and submit their calculations to their FIs as described in section I.C, revised CCRs will be applied retroactively in determining monthly interim TOP amounts attributable to any months occurring between August 1, 2000 and the date that the revised CCR is entered into the OPSF if a cost report including the month has not been filed. Retroactive recalculations of monthly interim TOP amounts will not be necessary for any months for which a cost report has been filed because any difference in interim TOP payments and actual TOP amounts determined on the cost report will be taken into account in the cost report settlement process, including tentative settlements. Retroactive adjustments of

interim TOP payments will not be required in future years as CCRs will be updated on a more timely basis as described in section I.E.

For providers that submit a CCR calculation as described in section I.C, if the revised CCR increases or decreases the amount the provider is entitled to for interim TOP payments and the provider's cost report for that period is due after April 30, 2003, you must take action to recoup any interim TOP amounts that were overpaid or make a lump-sum payment for any amounts underpaid. Any underpayment determined by a revision to the CCR must be paid to the provider in accordance with normal payment rules. You must make the lump sum payment no later than 30 days after the revised CCR has been entered into the OPSF. Any adjustments to the CCR that result in an overpayment must be handled and collected in accordance with the normal rules for overpayment collection.

The amount of the overpayment or underpayment attributable to interim TOP amounts for any month is the difference between the interim TOP amounts received by the provider that were calculated using the CCR that was in the OPSF prior to recalculating the CCR and the interim TOPs amounts the provider would have received using the revised CCR. If available, data from the Provider Statistical and Reimbursement Reports may be useful in determining the revised TOP amounts.

The lump sum payments supplement what intermediaries are already paying providers. Providers that receive (or are credited) these additional payments must add them to their cost reports. Providers must include the full amount of the lump sum payment on the cost report even if some or all of it was applied to reduce or recover overpayments. All lump sum adjustments must be reported on Worksheet E-1 of the hospital cost report and Worksheet S-1 of the CMHC cost report. Intermediaries that process cost reports must be sure that the tentative settlements of the cost reports reflect the proper payments, and that any resulting overpayment should be recovered according to normal cost reporting settlement procedures.

E. Ongoing CCR Updates

Following the initial update of CCRs for all hospitals and CMHCs subject to OPPS by April 30, 2003, intermediaries must continue to update a provider's CCR each time a more recent cost report is available as described in the introductory paragraph of section I. Revised CCRs must be entered into the OPSF not later than 30 days after the date of the tentative settlement or final settlement used in calculating the CCR. At the intermediary's discretion, CCRs may be revised more often if a change in a provider's operations occurs which materially affects a provider's costs or charges

F. Clarifications

- In the case of provider mergers or acquisitions or other such changes, the CCR for the surviving provider should be used.

- If a hospital or CMHC has a short period cost report its CCR must be calculated using the most recent full-year cost report.

- Separate instructions will be issued regarding updating CCRs for new providers that do not have a full-year cost report and providers that do not have a cost report for which costs and charges are available (e.g., hospitals using the all-inclusive method prior to OPPS). Until instructions are issued, in determining CCRs for these providers as well as for providers having a CCR that exceeds the expected upper CCR limits for hospitals and CMHCs discussed in sections I.A and I.B, intermediaries must enter into the provider's OPSF the applicable statewide average urban or rural hospital default CCRs that are currently being applied to new providers.

- If a cost report reopening results in adjustments that would change the CCR that is currently in effect, a corrected CCR must be calculated and entered in the OPSF within 30 days of the date the reopening is finalized.

II. Hospital Cost Report Identification of Outpatient Services Paid at Cost

When the OPPS was implemented, we excluded from the OPPS certain hospital outpatient services that were already being paid based on a fee schedule, or other prospective payment methods (e.g., clinical diagnostic laboratory services, physical, occupational and speech therapy, ESRD dialysis, etc.). We identified, by HCPCS code, the services that we believed were paid under one of these other methods by assigning a status indicator of "A" to them in Addendum B of the final rule we publish each year for OPPS. After the OPPS was implemented, we discovered that some of the services that we had identified as paid under another prospective method were, in fact, not assigned to another fee schedule. When those services appeared on a claim and no fee schedule amount was found in the claim pricing system, FIs made an interim payment and processed these line items as if they were to be paid on a reasonable cost basis. We are working to identify the services we incorrectly assigned a status indicator of "A" so that we can include those services under the OPPS. However, until such time as we are able to assign those services to ambulatory payment classifications for payment under the OPPS, the services will be paid on a cost basis.

Notify your providers that they are to report those services that were paid at cost and report those charges on Worksheet D, Part V, column 5.02 as appropriate. This will necessitate opening all lines for purposes of calculating the costs in column 9.02. Providers will need to request from their software vendors the updated programs, which will enable the inputs to all applicable lines in the aforementioned columns. The cost in column 9.02 will be subject to the lower of cost or charges (LCC) calculated on Worksheet E, Part B, where applicable.

The *effective date* for this PM is January 17, 2003.

The *implementation date* for calculating all provider CCRs and updating the OPSF is not later than April 30, 2003.

The *implementation date* for making interim TOP lump sum adjustments is not later than May 30, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 17, 2004.

If you have any questions contact your regional office.