HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2012

Medicare beneficiaries enrolled in the traditional fee-for-service program receive care in over 3,500 facilities that contract with Medicare to provide acute inpatient care and agree to accept the program's predetermined payment rates as payment in full.[1] Payments made under the acute inpatient prospective payment system (IPPS) totaled $116 billion and accounted for about 25 percent of Medicare spending in 2010. These payments provide about 20 percent of hospitals' overall revenues.

Medicare's inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. In 2012, beneficiaries are liable for a deductible of $1,156 for the first hospital stay in an episode, and daily copayments—currently $289—are imposed beginning on the 61st day.

As outlined in Figure 1, the IPPS pays per discharge rates that begin with two national base payment rates—covering operating and capital expenses—which are then adjusted to account for two broad factors that affect hospitals' costs of furnishing care:

- the patient's condition and related treatment strategy, and
- market conditions in the facility's location.

To account for the patient's needs, Medicare assigns discharges to Medicare severity diagnosis related groups (MS–DRGs), which group patients with similar clinical problems that are expected to require similar amounts of hospital resources. Each MS–DRG has a relative weight that reflects the expected relative costliness of inpatient treatment for patients in that group. To account for local market conditions, the payment rates for MS–DRGs in each local market are determined by adjusting the national base payment rates to reflect the relative input-price level in the local market. In addition to these two factors, the operating and capital payment rates are increased for facilities that operate an approved resident training program or that treat a disproportionate share of low-income patients. Conversely, rates are reduced for certain transfer cases, and outlier payments are added for cases that are extraordinarily costly.

The IPPS payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high quality care.

Defining the inpatient acute care products Medicare buys

Under the IPPS, Medicare sets per discharge payment rates for 751 severity-adjusted MS–DRGs, which are based on patients' clinical conditions and treatment strategies. Clinical conditions are defined by both the patients' discharge diagnoses, including the principal diagnosis—the main problem requiring inpatient care—and up to eight secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical—is defined by the presence or absence of up to six procedures performed during the stay.

The MS–DRG system has 335 base DRGs, most of which are split into 2 or 3 MS–DRGs based on the presence of either a comorbidity or complication (CC) or major CC. Discharge destination and use of a specific drug are occasionally used along with principal diagnosis and procedures in structuring base DRGs.

This document does not reflect proposed legislation or regulatory actions.

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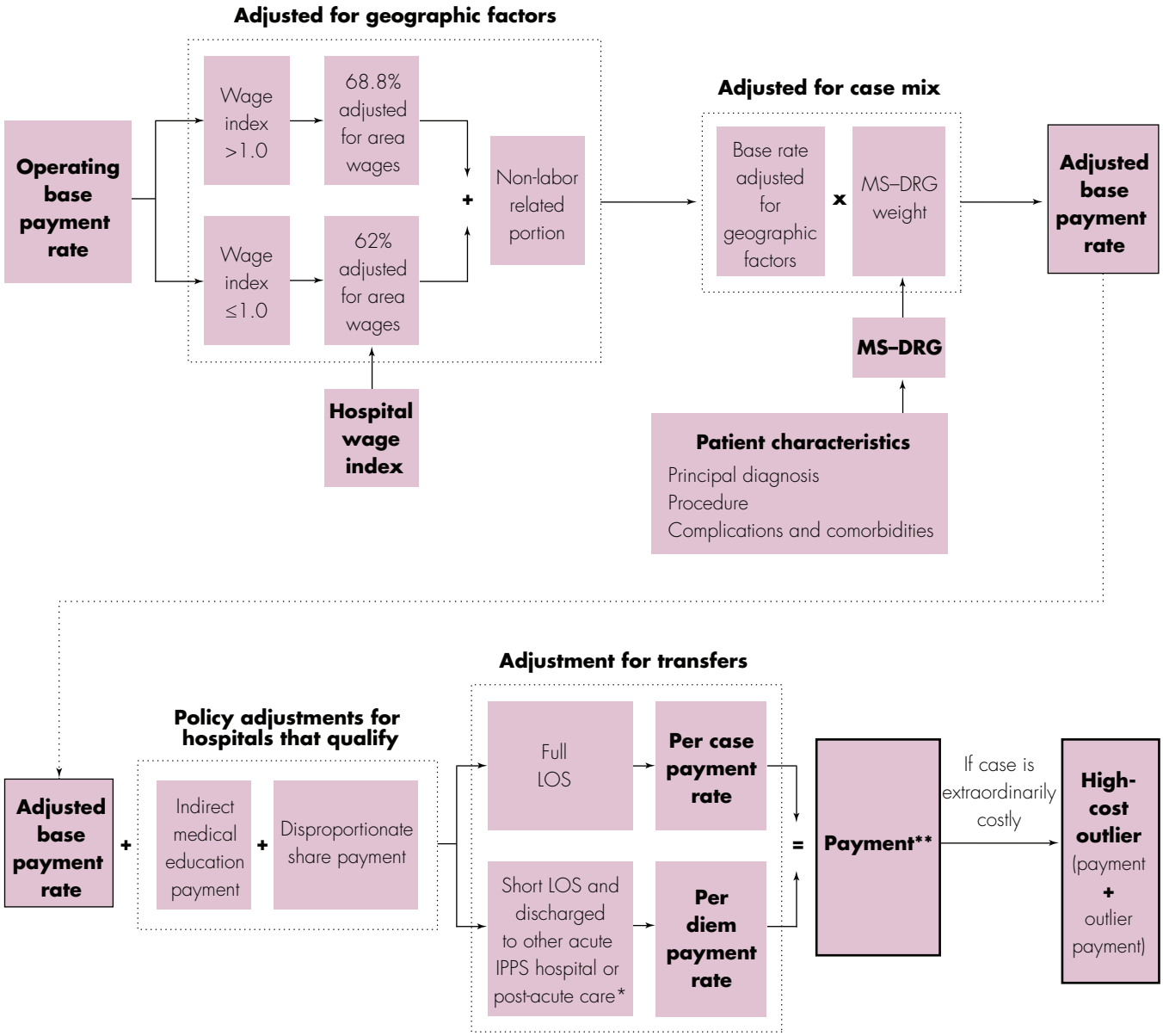
Figure 1 Acute inpatient prospective payment system



Note: MS–DRG (Medicare severity diagnosis related group), LOS (length of stay), IPPS (inpatient prospective payment system). Capital payments are determined by a similar system.
* Transfer policy for cases discharged to post-acute care settings applies for cases in 275 selected MS–DRGs.
** Additional payment made for certain rural hospitals.

CMS annually reviews the MS–DRG definitions to ensure that each group continues to include cases with clinically similar conditions requiring comparable amounts of inpatient resources. When the review shows that subsets of clinically similar cases within an MS–DRG consume significantly different amounts of resources, CMS often reassigns them to a different MS–DRG with comparable resource use or creates a new MS–DRG.

Facing fixed payment rates, providers have financial incentives to reduce their inpatient costs by moving some services to another setting. Medicare has adopted policies to counter these incentives. Thus, related outpatient department

services delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (referred to as the 72-hour rule). Similarly, payment is reduced when patients have a short length of stay and are transferred to another acute care hospital or, in many MS–DRGs, when patients are discharged to post-acute care settings.

Setting the payment rates

Medicare's payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The two base rates are updated annually and are adjusted to reflect patient conditions, market conditions, and other factors recognized under Medicare's payment system. In 2013, the update is equal to the market basket (which measures the price increase of goods and services hospitals buy to produce patient care) less 0.1 percentage points and less the current 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. The Secretary determines the capital update. Payments to hospitals that fail to provide data on specified quality indicators are reduced by 2 percent.

The base payment amounts Medicare sets per discharge base rates (known as standardized payment amounts) for the operating and capital costs that efficient facilities would be expected to incur in furnishing covered inpatient services. Operating payments cover labor and supply costs; capital payments cover costs for depreciation, interest, rent, and property-related insurance and taxes. For fiscal year 2013, the operating base rate is $5,349.[2] The capital rate is $425.

Certain costs are excluded from the acute inpatient PPS and paid separately, such as the direct costs of operating graduate medical education programs and organ acquisition costs.

The MS–DRG relative weights Medicare's operating and capital base rates are adjusted by an MS–DRG weight to reflect the patient's condition. Medicare assigns a weight to each MS–DRG reflecting the average relative costliness of cases in that group compared with that for the average Medicare case. CMS recalibrates the MS–DRG weights annually, without affecting overall payments, based on standardized costs for all PPS cases in each MS–DRG.

Adjustment for market conditions
Medicare's base operating and capital rates are adjusted by an area wage index to reflect the expected differences in local market prices for labor.[3] The wage index is intended to measure differences in hospital wage rates among labor markets; it compares the average hourly wage for hospital workers in each metropolitan statistical area or statewide rural area to the nationwide average.[4] The wage index is revised each year based on wage data reported by IPPS hospitals.

The wage index is applied to the labor-related portion of the base rate (usually called the "labor share"), which reflects an estimate of the portion of costs affected by local wage rates and fringe benefits. CMS's current operating labor share estimate of 68.8 percent is applied to hospitals with a wage index above 1.0. The Congress has legislated an operating labor share of 62 percent for hospitals located in areas with a wage index less than or equal to 1.0.

New technology payments Hospitals with cases treated using certain cost-increasing technologies receive add-on payments for new technologies. CMS evaluates applications by technology firms and others for add-on payments based on criteria of newness, substantial clinical improvement, and the costliness of the technology beyond the level of the current MS–DRG payment amount. New technology payments are additional to the MS–DRG payment and thus are not budget neutral.

Bad debts Medicare reimburses acute-care hospitals for 65 percent of bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts.

Policy adjustments Certain hospitals receive additional operating and capital payments. Qualifying hospitals include those that operate medical resident training programs, treat a disproportionate share of low-income patients, or are located in a rural area and meet certain criteria. In addition, over 1,300 rural hospitals qualify as critical access hospitals and are paid on a cost basis (incurred costs plus 1 percent) instead of under the IPPS. The *Critical Access Hospitals Payment System* document in our "Payment Basics" series provides more information on this topic.

Medical education payments Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with resident training. Nearly 95 percent of teaching facilities are located in urban areas, although they serve Medicare beneficiaries living in both urban and rural areas.

The size of the indirect medical education (IME) adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by a hospital's number of residents per bed.

For fiscal year 2013, the operating IME adjustment is roughly 5.5 percent for every 10 percent incremental increase in the resident-to-bed ratio.

Medicare pays separately for the direct costs of operating approved training programs for medical, dental, or podiatric residents. These graduate medical education (GME) payments are based on hospital-specific costs per resident in a base year. The per resident payment amounts are frozen for hospitals with amounts above 140 percent of the national average.

Disproportionate share payments Hospitals that treat a disproportionate share (DSH) of certain low-income patients receive additional operating and capital payments thought to offset the financial effects of these patients. A hospital's low-income patient share is the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. The low-income patient share does not factor in uninsured patients. Any hospital with a low-income share exceeding 15 percent is eligible to receive operating DSH payments based on a complex formula. However, the add-on rate is capped at 12 percent of base inpatient payments for most rural hospitals and urban facilities with fewer than 100 beds.[5]

The capital DSH add-on payments are much smaller than DSH operating add-ons because the capital adjustment is based on the empirically estimated cost effect of treating low-income patients, while the operating adjustment is set substantially above the empirical level.

Special payments for rural hospitals Medicare makes additional payments to certain rural hospitals, although some urban facilities also may qualify. Hospitals located at least 35 miles from the nearest like hospital (excluding CAHs and Indian Health Service hospitals) are eligible for the sole community hospital (SCH) program. These facilities receive the higher of payments under the IPPS or payments based on their costs in a base year updated to the current year and adjusted for changes in their case mix.

The Medicare-dependent hospital (MDH) program is for small rural hospitals in which Medicare patients comprise at least 60 percent of their admissions or patient days. These hospitals receive IPPS payments plus 75 percent of the difference between those payments and payments based on their updated base-year costs. This policy expired at the end of fiscal year 2012.

For fiscal years 2012 and 2013 hospitals receive an additional payment if they qualify as a low-volume facility. However, the low-volume policy changed significantly for fiscal year 2013. For fiscal year 2012, low-volume facilities were defined based on their Medicare discharges (fewer than 1,600 discharges) and were required to be located more than 15 miles from the nearest

like hospital. These hospitals received as much as a 25 percent add-on to the prospective rate of each case, depending on their number of Medicare discharges. For fiscal year 2013, low-volume facilities are defined based on their total discharges (200 or fewer, including Medicare) and must be at least 25 miles from the nearest like hospital. These hospitals receive a 25 percent add-on to the prospective rate for each case.

Readmissions reduction policy As required by the Patient Protection and Affordable Care Act of 2010 (PPACA), the hospital readmission reduction program is being implemented beginning in fiscal year 2013. As a part of this program, hospitals that have excess Medicare readmissions for selected conditions will have their IPPS payments reduced. In fiscal year 2013 and fiscal year 2014 the readmissions policy will apply to just three conditions (acute myocardial infarction, heart failure, and pneumonia). Hospitals whose Medicare risk-adjusted readmission rates are greater than the national average rates will have their IPPS payments reduced. The payment penalty is capped at 1 percent of a hospital's base DRG payments in 2013.

Value-based incentive payments As mandated by PPACA, the value-based incentive payment program will be implemented in fiscal year 2013. For the first year of the program CMS will redistribute a pool of dollars equal to 1 percent of base inpatient DRG payments (estimated as $850 million in fiscal year 2013) to hospitals based on their overall performance on a set of quality measures. The size of the value-based purchasing redistribution pool will increase by 0.25 percentage points each year, reaching a maximum of 2 percent of DRG payments for fiscal year 2017.

Outlier payments Some cases are extraordinarily costly, producing losses that may be too large for hospitals to offset. Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital MS–DRG payments.

Outlier cases are identified by comparing their costs to an MS–DRG-specific threshold that is the sum of the hospital's:

- MS–DRG payment for the case (both operating and capital),
- any IME, DSH, and new technology payments, and
- a fixed loss amount.

CMS sets a national fixed loss amount ($21,821 for fiscal year 2013), which is adjusted to reflect input price levels in the hospital's local market. Outlier payments are financed by prospective offsetting reductions in the operating base rate (5.1 percent) and the capital base rate (4.9 percent). CMS sets the national fixed loss amount at the level it estimates will result in outlier payments equaling the offset. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds.

Transfer policy Medicare reduces MS–DRG payments when patients:

- have a length of stay at least one day less than the geometric mean length of stay for the MS–DRG, [6]
- and are transferred to another hospital covered by the acute inpatient PPS, or in 275 MS–DRGs, are discharged to a post-acute care setting.

The post-acute settings covered by the transfer policy include long-term care hospitals; rehabilitation, psychiatric or skilled nursing facilities; and home health care if the patients receive clinically related care that begins within three days after the hospital stay.

Transferring facilities under this policy are paid a per diem rate rather than the full MS–DRG payment. Generally, hospitals receive twice the per diem rate for the first day and the per diem rate for each additional day up to the full MS–DRG rate.[7] ■

1 Medicare pays the approved amount minus any beneficiary liability, such as a deductible or copayment; the provider then collects the remaining amount from the beneficiary or a supplemental insurer.

2 Hospitals in Puerto Rico receive a 75/25 blend of the federal base payment amount and a Puerto Rico-specific rate.

3 A hospital may request geographic reclassification to an adjacent market area for its wage index and capital geographic adjustment factor. To qualify, a hospital must demonstrate proximity (location within 15 miles of the border of the adjacent area for urban hospitals and 35 miles for rural hospitals). It also must show that its hourly wages are above average for its market area (above 106 percent for rural hospitals and 108 percent for urban hospitals) and comparable to wages in the area to which it seeks reclassification (at least 86 percent of that area's average for rural hospitals and 88 percent for urban hospitals) in fiscal year 2011. Some hospitals also qualify for a higher wage index based on county commuting patterns of their employees.

4 In 2007, CMS implemented an occupational mix adjustment to the hospital wage index for nursing-related personnel. This adjustment is designed to ensure that wage index values do not reflect the effects of differences in mix of workers (a greater share of RNs and smaller share of nurse aides in some areas, for example).

5 The 12 percent cap does not apply to rural facilities with at least 500 beds, rural referral centers, or Medicare-dependent hospitals. An add-on of 35 percent of base inpatient payments is available for hospitals that receive at least 30 percent of their inpatient revenue (excluding Medicare and Medicaid) from state and local government subsidies. These are referred to as "Pickle" hospitals.

6 A geometric mean gives less weight to unusually long lengths of stay than an arithmetic mean, thus producing a lower estimate of the average length of stay and fewer cases affected by the transfer policy.

7 An exception exists for certain MS–DRGs with high first-day costs. These transfer cases are paid half the full MS–DRG payment plus one per diem payment and half the per diem rate for subsequent days up to the full MS–DRG rate.