
Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
Acute Inpatient Prospective Payment System
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Facilities contract with Medicare to furnish acute inpatient care and agree to accept predetermined acute **Inpatient Prospective Payment System** (IPPS) rates as payment in full.

The 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 Skilled Nursing Facility (SNF) for 60 consecutive days.

The IPPS pays per-discharge rates that begin with two national base payment rates that cover operating and capital expenses, which are then adjusted to account for the following factors that affect hospitals' costs of furnishing care:

- The patient's condition and related treatment strategy; and
- Market conditions in the facility's location.

Discharges are assigned to diagnosis related groups (DRGs), which group patients with similar clinical problems that are expected to require similar amounts of hospital resources. Each DRG has a relative weight that reflects the expected costliness of inpatient treatment for patients in that group. The payment rates for DRGs in each local market are determined by adjusting the base payment rates to reflect the input-price level in the local market which is then multiplied by the relative weight for each DRG. The operating and capital payment rates are increased for facilities that train residents in approved graduate medical education (GME) programs or treat a disproportionate share of low-income patients. Rates are reduced for certain transfer cases, and high cost outlier payments are added for cases that are extremely costly. In addition, hospitals may be paid an additional amount for treating with new technologies. Technologies approved for add-on payments are new, costly, and a substantial clinical improvement over existing treatments.

IPPS payment rates are intended to cover the average costs that a provider will incur in furnishing care for one type of case relative to another. The chart on page 3 shows the formula for calculating Medicare's IPPS operating base payment rate.

The steps are as follows:

1) A standardized amount (a dollar figure) is divided into labor and non-labor related portions and the labor portion is adjusted by a wage index to reflect area differences in the cost of labor. If the wage index is greater than 1, the labor share equals 69.7 percent. The law requires the labor share to equal 62 percent if the wage index is less than 1.0.
2) The wage adjusted labor share is added to the non-labor share of the standardized amount.
3) The wage adjusted standardized amount is multiplied by a relative weight for the DRG. The relative weight is specific to each of 745 DRGs (for fiscal year [FY] 2008) and represents the relative average cost of a patient in one DRG compared to another.
4) If applicable, additional amounts will be added to the IPPS payment for hospitals engaged in teaching medical residents, hospitals that treat a disproportionate share of low income patients, and high cost outlier cases.

The chart on page 4 shows the formula for calculating Medicare's IPPS capital base payment rate. Under the IPPS, DRG per-discharge payment rates are based on patients' clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay. The patient's principal diagnosis and up to eight secondary diagnoses that indicate comorbidities and complications will determine the DRG assignment. Similarly, DRG assignment can be affected by up to six procedures furnished during the stay.

The Centers for Medicare & Medicaid Services (CMS) reviews the DRG definitions annually to ensure that each group continues to include cases with clinically similar conditions that require comparable amounts of inpatient resources. When the review shows that subsets of clinically similar cases within a DRG consume significantly different amounts of resources, they are assigned to a different DRG with comparable resource use or a new DRG is created. For discharges occurring on or after October 1, 2007, a new DRG system called Medicare Severity (MS)-DRGs is being used to better account for severity of illness and resource consumption for Medicare patients. Use of MS-DRGs will be transitioned during a two-year period. For the period October 1, 2007 through September 30, 2008, payment will be based on a 50/50 blend of MS-DRGs and the previous DRG system. There are three levels of severity in the MS-DRGs based on secondary diagnosis codes:

1) MCC—Major Complication/Comorbidity, which reflect the highest level of severity;
2) CC—Complication/Comorbidity, which is the next level of severity; and
3) Non-CC—Non-Complication/Comorbidity, which do not significantly affect severity of illness and resource use.

Related outpatient department services delivered on the day of or three days prior to admission are included in the payment for the inpatient stay and may not be separately billed. Payment is also reduced when a patient has a short length of stay (LOS) and is transferred to another acute care hospital or, in some circumstances, to a post-acute care setting.

HOW PAYMENT RATES ARE SET

IPPS payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The base rates are updated annually and unless there are other policy changes, the update raises all payment rates proportionately.

Base Payment Amounts

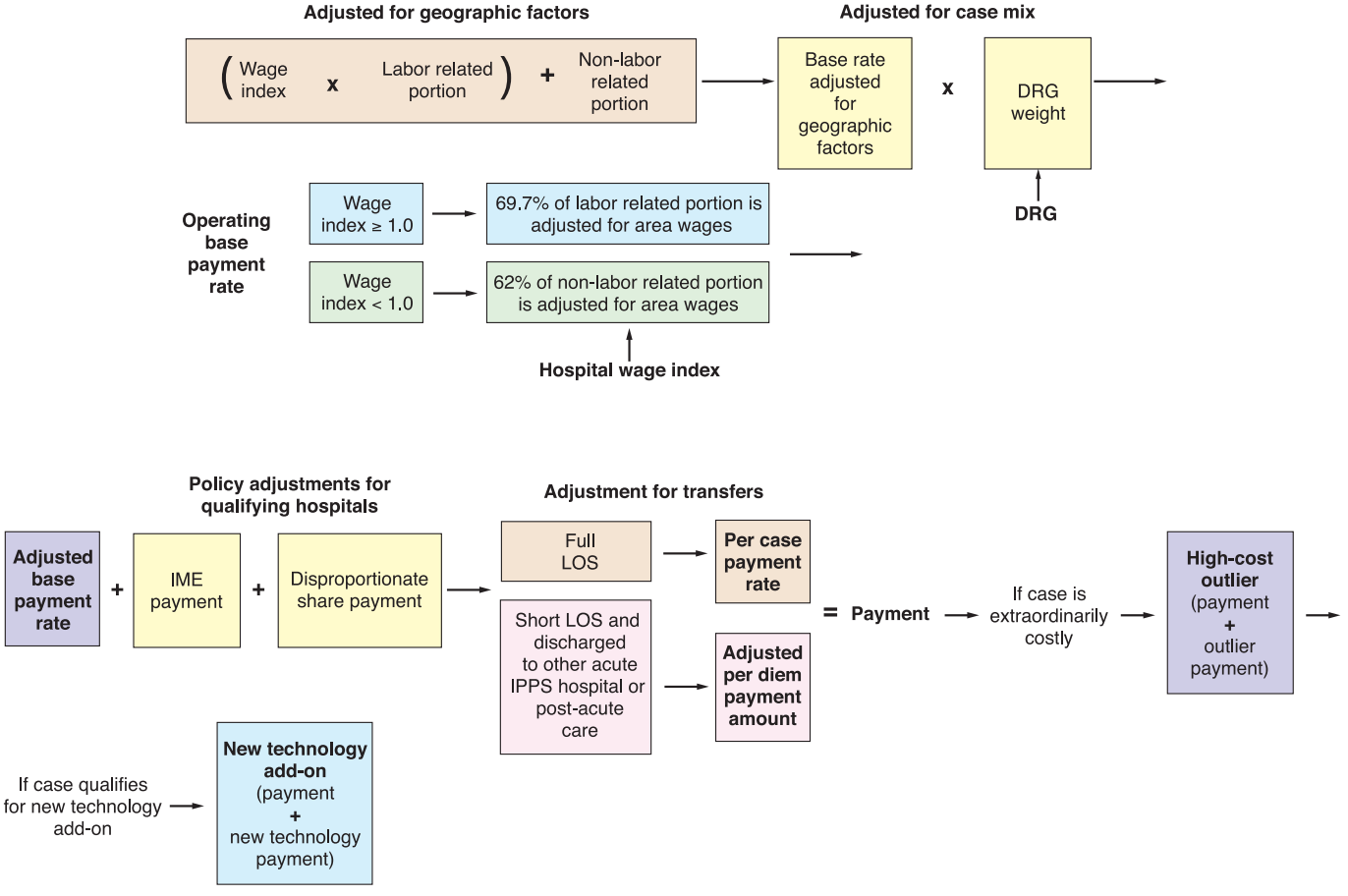
Discharge base rates, also known as standardized payment amounts for operating payments and the Federal rate for capital payments, are set for the operating and capital costs that efficient facilities would be expected to incur in furnishing covered inpatient services. Some costs, such as direct costs of operating GME programs and organ acquisition costs, are excluded from the IPPS and paid separately. Operating payments cover labor and supply costs. For FY 2008, the national IPPS operating base rate is $4,990.60. Capital payments cover costs for depreciation, interest, rent, and property-related insurance and taxes. For FY 2008, the national IPPS capital base rate is $426.14. Hospitals in Puerto Rico receive a 75 percent/25 percent blend of the Federal base payment amount and a Puerto Rico-specific rate respectively for both operating and capital payments.

Diagnosis Related Group Relative Weights

A weight is assigned to each MS-DRG that reflects the average relative costliness of cases in that group compared with the costliness for the average Medicare case. The same MS-DRG weights are used to set operating and capital payment rates. The MS-DRG weights are recalibrated annually, without affecting overall payments, based on standardized charges and costs for all IPPS cases in each MS-DRG. Hospitals' billed charges are standardized to improve comparability, which involves adjusting charges to remove differences associated with hospital wage rates across labor markets, the size and intensity of hospitals' resident training activities, and the number of low-income patients treated by a hospital. The charges are reduced to costs by using national average ratios of hospital costs to charges for 15 different hospital departments.

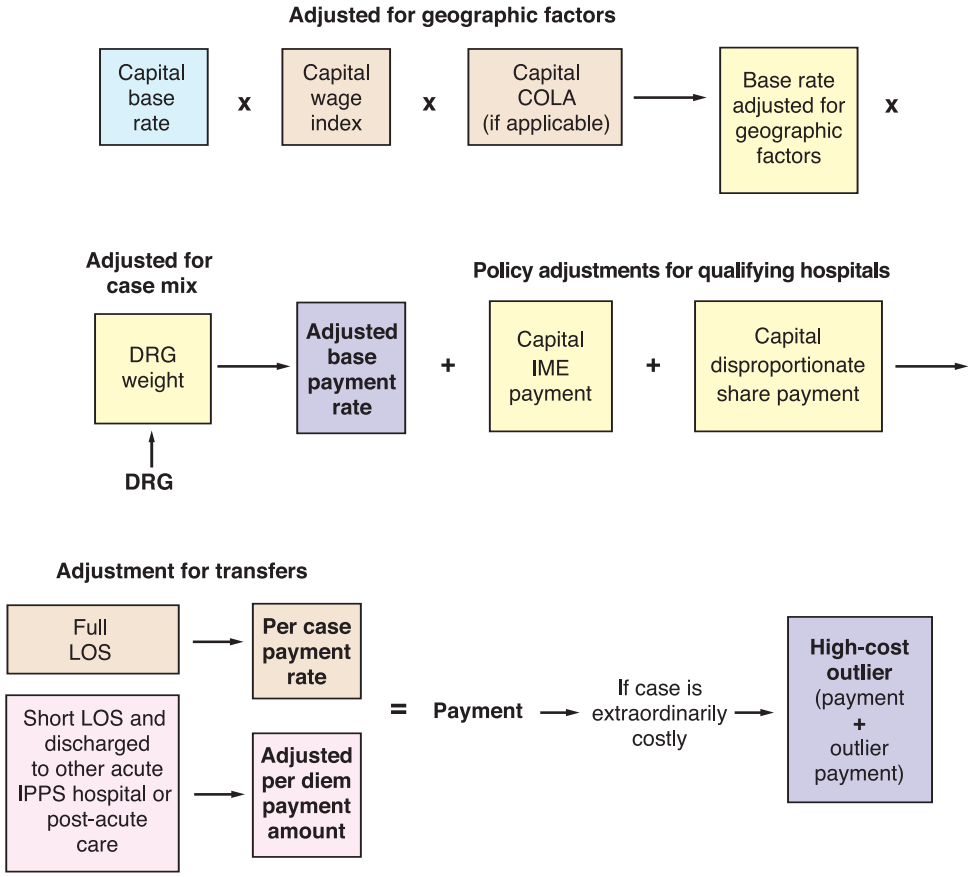
Acute Inpatient Prospective Payment System

Operating Base Payment Rate



Acute Inpatient Prospective Payment System

Capital Base Payment Rate



Adjustment for Market Conditions

Base operating and capital rates are adjusted by an area wage index to reflect the expected differences in local market prices for labor, which is intended to measure differences in hospital wage rates among labor markets by comparing the average hourly wage for hospital workers in each urban or statewide rural area to the nationwide average. CMS uses the Office of Management and Budget's Core Based Statistical Area definitions (with some modifications) to define each labor market area. The wage index is revised each year based on wage data reported by IPPS hospitals. Hospitals may request geographic reclassification if they believe that they compete for labor with a different area than the one in which they are located. A cost-of-living adjustment (COLA), which reflects the higher costs of supplies and other nonlabor resources, is also applied to the base operating and capital rates of IPPS hospitals in Hawaii and Alaska. The wage index is applied to the labor-related portion or labor share of the operating base rate, which reflects an estimated portion of costs affected by local wage rates and fringe benefits, and applied to the whole capital base rate. The current estimate of the national operating labor share is 69.7 percent, which is applied to hospitals with a wage index greater than or equal to 1.0. The national operating labor share is 62 percent for areas with a wage index less than 1.0. There are alternative labor shares that are applicable to hospitals located in Puerto Rico. The wage index applied to the capital base rate is raised to a fractional power, which narrows the geographic variation in wage index values among market areas. Effective October 1, 2007, the three percent capital large urban add-on was eliminated.

Bad Debts

Acute care hospitals are reimbursed for 70 percent of bad debts resulting from beneficiaries' nonpayment of copayments and deductibles after a reasonable effort has been made to collect the unpaid amounts.

Policy Adjustments

Additional operating and capital amounts are paid to the following hospitals:

- Teaching hospitals or hospitals that train residents in approved medical, osteopathic, dental, or podiatry residency programs receive add-on payments called indirect medical education (IME) adjustments to reflect the higher indirect patient

care costs of teaching hospitals relative to non-teaching hospitals. The size of the IME adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by the hospital's number of residents trained per inpatient bed (i.e., the resident-to-bed ratio). In FY 2006, the operating IME adjustment increased per-case payments by 5.55 percent for approximately every 10 percent increase in the resident-to-bed ratio. In FY 2007, the rate was 5.35 percent and in FY 2008, the rate is 5.5 percent. The capital IME adjustment is empirically based on the measured effect of teaching intensity on hospitals' costs. Direct GME payments reflect the direct costs of operating approved residency training programs and are paid separately from the IPPS. Direct GME payments are generally based on the product of:

- Hospital-specific costs per resident in a historical base year and
- The number of residents a hospital trains and
- The hospital's Medicare patient load (the proportion of Medicare inpatient days to total inpatient days)

- Hospitals that treat a disproportionate share of low-income patients receive additional operating and capital payments. A hospital can qualify for the Medicare operating disproportionate share hospital (DSH) adjustment by using one of the following methods:
  - Primary method—The hospital's DSH percentage exceeds an amount specified in statute. The DSH percentage equals the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income and the percentage of total inpatient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A.
  - Alternate method (known as the Pickle methodology)—Large urban hospitals qualify for DSH if they can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local governments for indigent care (other than Medicare or Medicaid).

For hospitals with a DSH percentage that exceeds 15 percent, operating DSH payments are based on a statutory formula. The add-on rate is capped at 12 percent of base inpatient payments for rural hospitals with fewer than 500 beds and for urban hospitals with fewer than 100 beds. Rural Referral Center payments are based on a separate formula. For hospitals that receive at least 30 percent of inpatient revenue from State and local government subsidies, a 35 percent adjustment rate applies. Urban hospitals with 100 or more beds and hospitals that receive at least 30 percent of inpatient revenue from State and local government subsidies are eligible for capital DSH payments (regardless of their DSH patient percentage). The capital DSH add-on payment is based on the empirically estimated cost effect of treating low-income patients.

- For operating IPPS payments, Sole Community Hospitals (SCH) receive the higher of either the IPPS payment rate or a payment based on costs in a base year updated to the current year and adjusted for changes in their case mix. (Capital PPS payments are solely based on the capital base rate for SCHs, just like all other hospitals.) Facilities that are more than 25 miles from the nearest hospital and have fewer than 200 inpatient discharges from all payment sources receive a 25 percent add-on to their prospective rate. SCHs are located more than 35 miles from other like hospitals or are located in a rural area AND meet at least ONE of the following three conditions:

  1) The hospital is located between 25 and 35 miles from other like hospitals AND meets ONE of the following criteria:
     - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area
     - The hospital has fewer than 50 beds and would meet the 25 percent criterion above were it not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital or
     - Other like hospitals are inaccessible for at least 30 days in each of two out of three years because of local topography or prolonged severe weather conditions.

2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years.

3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest hospital is at least 45 minutes.

Rural hospitals that qualify as Critical Access Hospitals (CAH) are paid on a cost basis rather than under the IPPS.

Outlier Payments

To promote access to high quality inpatient care for seriously ill beneficiaries, additional payments are made for outlier or extremely costly cases that produce losses that may be too large for hospitals to offset with other less costly cases in the same DRG. These cases are identified by comparing their estimated operating and capital costs to a DRG-specific threshold that is the sum of the hospital's:

- DRG payment, consisting of both operating and capital, for the case;
- IME, DSH, and new technology payments; and
- A fixed loss amount.

The fixed loss amount is set each year, which is adjusted to reflect input price levels in the hospital's local market. The fixed loss amount for FY 2006 was $23,600, for FY 2007 it was $24,485, and for FY 2008 it is $22,185. Outliers are financed by offsetting reductions in the operating and capital base rates. The national fixed loss amount is fixed at the estimated level that will result in outlier payments equaling the offset (i.e., there is a reduction to the rates paid to all cases so that the amount paid as outliers does not increase or decrease estimated Medicare spending). Hospitals are paid 80 percent of their costs above their fixed loss thresholds and 90 percent of costs above the outlier threshold for burn cases.

Transfer Policy

DRG payments are reduced when:

- The patient's LOS is at least one day less than the geometric mean LOS for the DRG; and
- The patient is transferred to another hospital covered by the acute IPPS or, for certain MS-DRGs, discharged to a post-acute setting.

The following post-acute care settings are included in the transfer policy:

- Long-term care hospitals;
- Rehabilitation facilities;
- Psychiatric facilities;
- SNFs;
- Home health care when the patient receives clinically related care that begins within three days after the hospital stay;
- Rehabilitation distinct part (DP) units located in an acute care hospital or a CAH;
- Psychiatric DP units located in an acute care hospital or a CAH;
- Cancer hospitals; and
- Children's hospitals.

Payment Updates

The operating and capital payment rates are updated annually. The operating update, by statute, is currently set at the projected increase in the market basket index, which measures the price increases of goods and services hospitals buy to produce patient care. The Secretary of the Department of Health and Human Services (HHS) determines the capital update based on an update framework. Hospitals that report specific quality data to HHS receive the full market basket rate of increase for the update to the operating base rate. If a hospital does not report the quality data, it will receive the operating market basket rate of increase less 2.0 percentage points. (Currently there is adjustment to the capital update based on the reporting of quality data.)

To find additional information about the acute IPPS, visit **http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp** on the CMS website.

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