

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Acute Care Hospital Inpatient Prospective Payment System

PAYMENT SYSTEM FACT SHEET SERIES





immediately preceding the date of a beneficiary's inpatient admission must be included on the claim for the beneficiary's inpatient stay and must not be separately billed to Medicare Part B.

Discharges are assigned to diagnosis-related groups (DRG), a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay. The beneficiary's principal diagnosis and up to 24 secondary diagnoses that indicate comorbidities and complications will determine the DRG assignment. Similarly, DRG assignment can be affected by up to 25 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, CMS may assign them to a different DRG with comparable resource use or create a new DRG.

For discharges occurring on or after October 1, 2007, CMS is using a new DRG system called Medicare Severity (MS)-DRG to better account for severity of illness and resource consumption for Medicare beneficiaries. Use of MS-DRGs was transitioned during a two-year period. For the period October 1, 2007, through September 30, 2008, payment was based on a 50/50 blend of MS-DRGs and the previous DRG system. Beginning October 1, 2008 (fiscal year [FY] 2009) and after, payment is based solely on the MS-DRGs.

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.

Payment Rates

The IPPS per-discharge payment is based on two national base payment rates or "standardized amounts": one that provides for operating expenses

This publication provides the following information about the Acute Care Hospital Inpatient Prospective Payment System (IPPS):

- ❖ Background;
- ❖ Basis for IPPS payment;
- ❖ Payment rates;
- ❖ How payment rates are set; and
- ❖ Resources.

Background

Facilities contract with Medicare to furnish acute hospital inpatient care and agree to accept predetermined acute IPPS rates as payment in full.

The inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness with an additional 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.

Basis for Inpatient Prospective Payment System Payment

Generally, hospitals receive Medicare IPPS payment on a per discharge or per case basis for Medicare beneficiaries with inpatient stays. All outpatient diagnostic services and admission-related outpatient nondiagnostic services provided by the admitting hospital or an entity that is wholly owned or operated by the admitting hospital on the date of a beneficiary's inpatient admission or within three days

and another for capital expenses. These payment rates are adjusted to account for:

- ❖ The costs associated with the beneficiary's clinical condition and related treatment relative to the costs of the average Medicare case (i.e., the DRG relative weight, as described in the "How Payment Rates Are Set" section below); and
- ❖ Market conditions in the facility's location relative to national conditions (i.e., the wage index, as described in the "How Payment Rates Are Set" section below).

In addition to these adjusted per discharge base payment rates, hospitals can qualify for outlier payments for cases that are extremely costly. Hospitals that train residents in approved Graduate Medical Education (GME) Programs also receive a payment separate from the IPPS for the direct costs of training residents. The operating and capital payment rates for these teaching hospitals are increased to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals or indirect costs of graduate medical education (Indirect Medical Education [IME]). Operating and capital payment rates are also increased for facilities that treat a disproportionate share of low-income patients. In addition, hospitals may be paid an additional amount for treating patients with certain approved technologies that are new and costly and offer a substantial clinical improvement over existing treatments available to Medicare beneficiaries. Finally, in some cases, payment is reduced when a beneficiary 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.

The steps for determining an IPPS payment are as follows:

- 1) The hospital submits a bill to the Medicare Administrative Contractor (MAC) for each Medicare patient it treats. Based on the information on the bill, the MAC categorizes the case into a DRG;
- 2) The base payment rate, or standardized amount (a dollar figure), includes a labor-related and nonlabor-related share. The labor-related share is adjusted by a wage index to reflect area differences in the cost of labor. If the area wage index is greater than 1.0000, the labor share equals 68.8 percent. The law requires the labor

share to equal 62 percent if the area wage index is less than or equal to 1.0000. The nonlabor-related share is adjusted by a cost-of-living adjustment (COLA) factor, which equals 1.0000 for all States except Alaska and Hawaii;

- 3) The wage-adjusted standardized amount is multiplied by a relative weight for the DRG. The relative weight is specific to each of 751 DRGs (for FY 2012) and represents the relative average costs associated with one DRG; and
- 4) If applicable, additional amounts will be added to the IPPS payment as follows:
 - The hospital engages in teaching medical residents to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals;
 - The hospital treats a disproportionate share of low-income patients;
 - Cases that involve certain approved new technologies; and
 - High-cost outlier cases.

The charts on page 4 show the formulas for calculating the Acute Care Hospital IPPS operating base payment rate and the capital base payment rate.

How Payment Rates Are Set

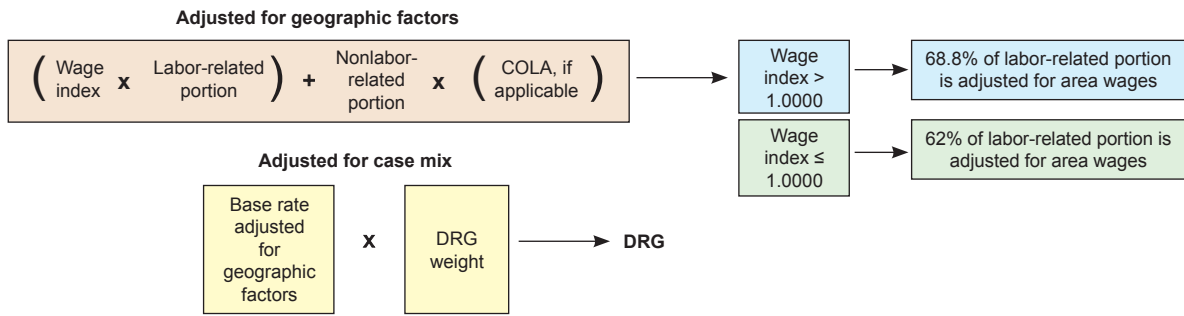
IPPS payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The base rates are updated annually and unless there are other policy changes, the update raises all payment rates proportionately.

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 are expected to incur in furnishing covered inpatient services. Some costs (e.g., direct costs of operating GME Programs and organ acquisition costs) are excluded from the IPPS and paid separately. For FY 2012, the national IPPS operating base rate is \$5,209.74. Capital payments cover costs for depreciation, interest, rent, and property-related

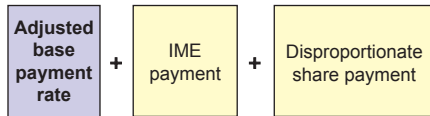
Acute Care Hospital Inpatient Prospective Payment System

Operating Base Payment Rate

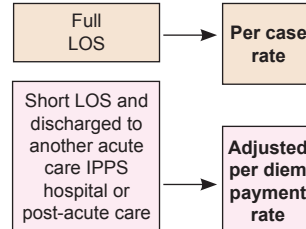


Policy adjustments for qualifying hospitals:

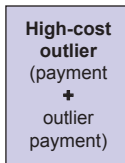
I. Additional operating amounts



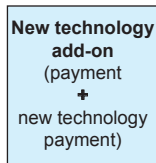
II. Adjustment for transfers



III. If case is extraordinarily costly

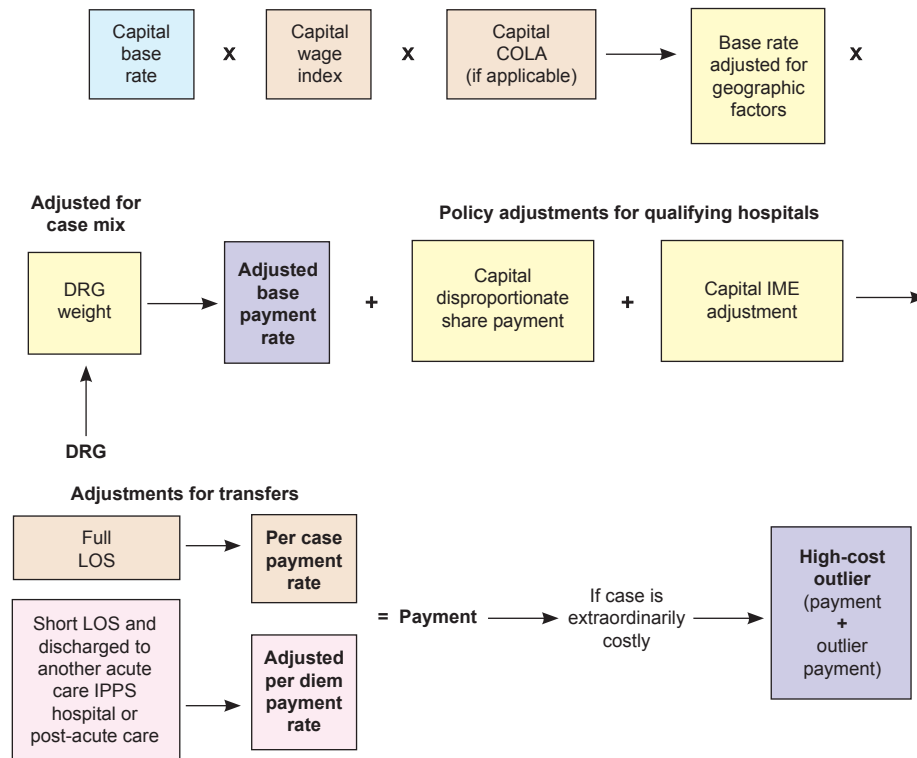


IV. If case qualifies for new technology add-on



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Capital Base Payment Rate





insurance and taxes. For FY 2012, the national IPPS capital base rate is \$421.42. 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 the hospital's resident training activities, and the number of low-income patients the hospital treats. The charges are reduced to costs by using national average ratios of hospital costs to charges for 15 different hospital departments.

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. A hospital may request geographic reclassification if it believes it competes for labor with a different area than the one in which it is located. A 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. Additionally, the wage index is applied to the whole capital base rate. The current estimate of the national operating labor share is 68.8 percent, which is applied to hospitals with a wage index greater than 1.0000. The national operating labor share is 62 percent for areas with a wage index less than or equal to 1.0000. 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.

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 as described below.

Direct Graduate Medical Education

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs receive Direct Graduate Medical Education (DGME) payments that reflect the direct costs of operating approved residency training programs and are paid separately from the IPPS. DGME payments are generally based on the product of:

- ❖ Updated 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).

Indirect Costs of Graduate Medical Education

Teaching hospitals or hospitals that train residents in approved medical, osteopathic, dental, or podiatry residency programs also receive 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 FYs 2009, 2010, and 2011, the operating IME adjustment increased per-case payments by 5.5 percent for approximately every 10 percent increase in the resident-to-bed ratio. In FY 2012, the rate is still 5.5 percent.

Medicare Disproportionate Share Hospitals

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 – Pertains to hospitals that serve a significantly disproportionate number of low-income patients and is based on the disproportionate patient percentage (DPP), which is equal to the sum of the percentage of Medicare inpatient days (including Medicare Advantage inpatient days) attributable to

patients entitled to both Medicare Part A and Supplemental Security Income and the percentage of total patient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A (including patient days not covered under Part A and patient days in which Part A benefits are exhausted). If a hospital's DPP equals or exceeds a specified threshold amount, the hospital qualifies for the Medicare DSH adjustment; or

- ❖ The alternate special exception method – Applies to hospitals that are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid). These hospitals are also known as "Pickle" hospitals. If a hospital qualifies under this method, the statute provides for a specific Medicare DSH adjustment.

For hospitals with a DSH patient percentage that exceeds 15 percent, operating DSH payments are based on a statutory formula. The DSH payment 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. Hospitals that qualify for a DSH payment under the Pickle methodology (i.e., they receive at least 30 percent of inpatient revenue from State and local government subsidies) have a 35 percent adjustment rate. Urban hospitals with 100 or more beds and all 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.

Sole Community Hospitals

Sole Community Hospitals (SCH) can receive operating payments based on their hospital-specific payment rate, while their capital payments are solely based on the capital base rate (i.e., like all other IPPS hospitals).

SCH payments are made based upon whichever of the following yields the greatest aggregate payment for the cost reporting period:

- ❖ The IPPS Federal rate applicable to the hospital;
- ❖ The updated hospital-specific rate based on FY 1982 costs per discharge;
- ❖ The updated hospital-specific rate based on FY 1987 costs per discharge;
- ❖ The updated hospital-specific rate based on FY 1996 costs per discharge; or
- ❖ The updated hospital-specific rate based on FY 2006 costs per discharge.

To qualify as a SCH, a hospital must meet one of the following criteria:

- 1) The hospital is located at least 35 miles from other like hospitals;

- 2) The hospital is rural (located in a rural area), 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; or
 - The hospital has fewer than 50 beds and would meet the 25 percent criterion above if 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;
- 3) The hospital is rural and 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; or
- 4) The hospital is rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.



A like hospital:

- ❖ Furnishes short-term, acute care;
- ❖ Is paid under the Acute Care Hospital IPPS;
- ❖ Is not a Critical Access Hospital (CAH); and
- ❖ Is not paid under any other Medicare PPS.

SCHs may also qualify for a payment adjustment for hospitals experiencing a significant volume decrease.

Certain hospitals formerly designated as Essential Access Community Hospitals are also treated as SCHs for payment purposes under the IPPS.

Medicare Dependent Hospitals

Medicare Dependent Hospitals (MDH) can also receive operating payments based on their hospital-specific payment rate, while their capital payments are solely based on the capital base rate.

For discharges on or after October 1, 2006, MDHs are paid for their inpatient operating costs based on the Federal rate or, if higher, the Federal rate plus 75 percent of the amount by which the Federal rate payment is exceeded by the MDH's updated hospital-specific rate payment based on its FY 1982, FY 1987, or FY 2002 costs per discharge, whichever of these hospital-specific rates is highest.

For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and ending before October 1, 2012, a MDH is an IPPS hospital that meets all of the following criteria:

- ❖ It is rural (located in a rural area);
- ❖ It has 100 or fewer beds during the cost reporting period;
- ❖ It is not also classified as a SCH; and
- ❖ At least 60 percent of its inpatient days or discharges were attributable to those beneficiaries entitled to Medicare Part A during the hospital's cost reporting period or periods as follows:
 - For its cost reporting period ending on or after September 30, 1987, and before September 30, 1988; or

- For its cost reporting period beginning on or after October 1, 1986, and before October 1, 1987 (only if the hospital does not have a cost reporting period that meets the preceding requirement); or
- For at least two of the last three most recent audited cost reporting periods for which there is a settled cost report.

If the cost reporting periods are for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

MDHs may also qualify for a payment adjustment for hospitals experiencing a significant volume decrease.

Low-Volume Hospitals

Under the Affordable Care Act, qualifying low-volume hospitals receive add-on payments in FYs 2011 and 2012 as follows:

- ❖ Those with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each discharge; and
- ❖ Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula $[(4/14) - (\text{Medicare discharges}/5600)]$.

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- ❖ Be more than 15 road miles from the nearest subsection (d) hospital; and
- ❖ Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data.

Qualifying Hospitals

Under Section 1109 of Public Law 111-152, qualifying hospitals will receive annual add-on payments in FYs 2011 and 2012. A qualifying hospital is located in a county that ranks per enrollee within the lowest quartile of such counties in the U.S. based on its ranking in age-, sex-, and race-adjusted spending for benefits under Medicare Parts A and B.



Outlier Payments

To promote access to high quality inpatient care for seriously ill beneficiaries, additional payments are made for outlier or extremely costly cases. These cases are identified by comparing their estimated operating and capital costs to a fixed loss threshold. The fixed loss amount is set each year, which is adjusted to reflect labor costs in the hospital’s local market. The table below shows the fixed loss amount for FYs 2010 – 2012.

Fixed Loss Amount

Fiscal Year	Fixed Loss Amount
2010	\$23,140 for discharges on or after October 1, 2010, through discharges on or before March 31, 2010
	\$23,135 for discharges on or after April 1, 2010, through discharges on or before September 30, 2010
2011	\$23,075
2012	\$22,385

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. Outliers are financed by offsetting reductions in the operating and capital base rates (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 aggregate Medicare spending). The national fixed loss amount is established at the level that will result in estimated outlier payments equaling 5.1 percent of total payments for the FY. To find an

outlier calculation example, visit http://www.cms.gov/AcuteInpatientPPS/Downloads/outlier_example_fy07.zip on the CMS website.

Transfer Policy

DRG payments are reduced when:

- ❖ The beneficiary’s LOS is at least one day less than the geometric mean LOS for the DRG;
- ❖ The beneficiary is transferred to another hospital covered by the Acute Care Hospital IPPS or, for certain MS-DRGs, discharged to a post-acute setting;
- ❖ The beneficiary is transferred to a hospital that does not have an agreement to participate in the Medicare Program (effective October 1, 2010); and
- ❖ The beneficiary is transferred to a CAH (effective October 1, 2010).

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 beneficiary 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 is set by Congress, considering the projected increase in the market basket index. The market basket index measures the price increases of goods and services hospitals buy to produce patient care. For FY 2012, the applicable percentage increase for IPPS hospitals equals the rate-of-increase in the hospital market basket

for IPPS hospitals in all areas reduced by 0.25 percentage point. 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 operating update set by Congress. In 2012, if a hospital does not report the quality data, it will receive the operating update of the rate-of-increase in the hospital market basket for IPPS hospitals in all areas reduced by 0.25 percentage point less an additional 2.0 percentage points. (Currently there is no adjustment to the capital update based on the reporting of quality data.)

Resources

For more information about the Acute Care Hospital IPPS, visit http://www.cms.gov/AcuteInpatientPPS/01_overview.asp and refer to the “Medicare Benefit Policy Manual” (Publication 100-02) and the “Medicare Claims Processing Manual” (Publication 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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