

Hospital inpatient services payment system

Each year, about one of every five Medicare beneficiaries enrolled in the traditional program has one or more inpatient stays in a short-term acute care hospital.¹ They receive care in more than 4,800 facilities that contract with Medicare to provide services and agree to accept the program's predetermined payment rates as payment in full.² Payments for inpatient care accounted for the largest component—about 40 percent—of Medicare spending in 2004. These payments also provide the largest single source of hospitals' revenues—about 23 percent of overall revenues.

From its inception in 1966 until 1983, Medicare paid hospitals for inpatient services based on their incurred costs. This payment method gave providers little incentive to produce services efficiently. Because they

were costly and relatively easy to distinguish, episodes of hospital inpatient care (stays) were the first to be converted to prospectively determined payment, beginning in fiscal year 1984. The hospital inpatient prospective payment system (PPS) is mature, but it nevertheless needs frequent adjustments to keep up with changes in technology, practice patterns, and market conditions that affect the amount and mix of resources hospitals use to furnish inpatient care.

The inpatient PPS pays hospitals predetermined per-discharge rates that are based primarily on two factors:

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

Using information about patients' diagnoses, procedures, and age reported on hospitals' claims, Medicare assigns discharges 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 national relative weight that reflects the expected relative costliness of inpatient treatment for a patient in that group compared with that for the average Medicare patient. Groups expected to require above-average resources have higher weights and those that require fewer resources have lower ones.

¹The Medicare inpatient hospital benefit covers beneficiaries for 90 days of care per illness episode, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted for care and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. In 2004, beneficiaries are liable for a deductible of \$876 for the first hospital stay in an episode. Daily copayments—currently \$219—are imposed beginning on the 61st day.

²Except for convenience items or services not covered by Medicare, providers are not permitted to charge beneficiaries more than the predetermined payment rate. Medicare pays the predetermined rate minus any beneficiary liability, such as a deductible or copayment; the provider then collects the remaining amount from the beneficiary or a supplemental insurer.

The payment rates for DRGs in each local market are determined by adjusting a national average base payment amount (the amount that would be paid for an average patient in a facility located in an average market) to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each DRG. Payment rates also are increased for facilities that operate approved physician (resident) training programs, for those that treat a disproportionate share of low-income patients, and for other factors.

Because the inpatient PPS accounts for a large share of Medicare spending, it faces ongoing scrutiny, often leading to technical and policy changes. The inpatient PPS payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high quality care, thereby rewarding those whose costs fall below the payment rates. However, financial performance under the inpatient PPS differs substantially among certain groups of hospitals. Some of these differences represent intended effects of policies adopted by the Congress. In other instances, they may reflect unintended results of inaccurate or inappropriate payment adjustments and failure to address factors that affect efficient providers' costs in certain circumstances. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes several provisions that significantly affect Medicare inpatient payments to hospitals.

Defining the hospital inpatient acute care products Medicare buys

Under the inpatient PPS, Medicare sets per-discharge payment rates for distinct types of treatment episodes represented by 516 DRGs, which are based on patients' clinical conditions and treatment strategies.³ Clinical

³Although the federal DRG classification system includes 540 categories, 24 are not used for Medicare payment.

conditions are described by 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 treatment—is described by the presence or absence of up to six procedures performed during the stay. Age is also occasionally used to distinguish groups of patients who are expected to use different amounts of resources.

The DRG definitions have a tree-like structure. Based on the principal diagnosis, cases are first assigned to one of 25 major diagnostic categories (MDCs), reflecting the affected organ system (such as the digestive system) or the etiology of the condition (such as burns or significant trauma). Within each MDC, cases are subdivided into those with and those without operating room or other significant procedures. Each of these broad groups is then further divided; the surgical group by type of procedure and the medical group by specific type of condition as indicated by the principal diagnosis. Finally, medical and surgical subgroups are often subdivided further to form DRGs distinguished by the presence or absence of comorbidities or complications indicated by specific secondary diagnoses.⁴

The Centers for Medicare & Medicaid Services (CMS) annually reviews the DRG definitions to ensure that they continue to include cases with clinically similar conditions requiring comparable amounts of inpatient resources. When the review shows that clinically similar cases within a DRG consume atypical quantities of resources, CMS often reassigns them to a different DRG with

⁴These groups are sometimes divided further to form DRGs for pediatric patients (under age 17).

comparable resource use; less often, CMS creates a new DRG.⁵

In return for Medicare's predetermined payment rates, hospitals are expected to furnish a reasonably well-defined bundle of inpatient services for each DRG. Facing fixed payment rates, however, providers have financial incentives to reduce their inpatient costs by moving some normally included services to another setting—such as an outpatient department or a skilled nursing facility—and bill those services separately. To counter these financial incentives, Medicare has adopted policies that help to strengthen the boundaries of the inpatient service bundles associated with the DRGs. Thus, patients must stay overnight before their discharges qualify for payment under the inpatient PPS. Related outpatient department services that were delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (the 72-hour rule). Similarly, payments for services may be reduced when patients are transferred to another hospital after a stay that is more than one day shorter than the national average stay for the DRG. The same payment reductions apply for certain DRGs when patients are transferred to post-acute care facilities, such as rehabilitation or skilled nursing facilities, or discharged to receive clinically related home health care that begins within three days.

Setting the payment rates

Medicare sets separate per-discharge operating and capital payment rates, which are intended to cover the operating and capital costs that efficient facilities would be expected to incur

⁵For example, CMS established a new DRG when it found that tracheostomy patients were substantially more costly than others in the same DRGs.

in furnishing covered inpatient services.⁶ Operating payment rates cover costs for labor and supplies; capital payment rates cover costs for depreciation, interest, rent, and property-related insurance and taxes. Medicare sets operating and capital payment rates using similar methods and factors.

The base payment amount Medicare sets one operating base payment amount (known as the standardized payment amount) representing what a hospital would be paid for operating expenses for an average Medicare patient (before any adjustments).⁷ The base operating amount per discharge for fiscal year 2004 is \$4,411. The MMA made permanent the use of a single operating base payment amount for all hospitals.

Capital payments have only recently been made fully prospective, having completed a 10-year phase-in during fiscal year 2001.⁸ The base capital rate for discharges from any hospital for fiscal year 2004 is \$414.

The diagnosis related group relative weights Medicare assigns a weight to each DRG reflecting the average relative costliness of cases in that group compared with that for the average Medicare case. The same DRG weights are used to set operating and capital payment rates. CMS recalibrates the DRG weights annually based on average

⁶Certain costs are excluded from the inpatient PPS and paid separately, such as direct costs of operating graduate medical education programs, organ acquisition costs, and bad debts related to beneficiaries' nonpayment of their cost-sharing liabilities (deductibles and copayments).

⁷Hospitals in Puerto Rico receive a 50/50 blend of the federal base payment amount and a Puerto Rico-specific rate. The MMA changed to blend to 75/25.

⁸New hospitals are exempt from prospective payment for capital costs for two years. During this period, they are paid 85 percent of their Medicare-allowable capital costs.

standardized billed charges for all PPS cases in each DRG in the most recent Medicare bill file.⁹

Hospitals with cases treated with certain 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, clinical benefit, and cost. The MMA liberalized the criteria for new technologies to qualify for add-on payments and allowed these payments to be made without budget neutrality.

Adjustment for market conditions Medicare's base operating and capital payment rates are adjusted to reflect the expected impact on efficient providers' costs of differences in local market prices for labor and other inputs. The base operating payment is adjusted by an area wage index; in Alaska and Hawaii, a cost of living adjustment (COLA) is also applied. The area 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 (MSA) or statewide rural area relative to the nationwide average.¹⁰ The

⁹Hospitals' billed charges are standardized to improve comparability. This involves adjusting charges to remove differences associated with variations in local market prices for inputs and those related to the size and intensity of hospitals' resident training activities.

¹⁰A hospital may request geographic reclassification to an adjacent market area for the standardized payment amount, the wage index (and capital geographic adjustment factor), or both. 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 82 percent of that area's average for rural hospitals and 84 percent for urban hospitals). The MMA permits hospitals to apply for a one-time appeal of their reclassification status, which lasts for three years, and also allows certain hospitals to qualify for a higher wage index based on county commuting patterns.

wage index is revised each year based on wage data reported by PPS hospitals on their annual Medicare cost reports. The COLA reflects the higher costs of supplies and other nonlabor resources in Alaska and Hawaii; it increases the nonlabor portion of PPS operating payments—38 percent of the total—for hospitals in these states by as much as 25 percent.

The wage index is applied to the labor-related portion of the standardized payment amount—62 percent of the total for fiscal year 2005—which reflects an estimate of the portion of operating costs affected by local wage rates and fringe benefits. The MMA increased payments to hospitals in low-wage areas by reducing the labor-related share from CMS's previous standard of 71 percent to 62 percent in areas with a wage index less than or equal to 1.0. Hospitals in higher-wage areas (with a wage index above 1.0) are held harmless.

The federal rate for capital payments is adjusted to reflect local market conditions using a geographic adjustment factor (which is based on the area wage index) and, for Alaska and Hawaii, the same COLA. The federal rate is increased by 3 percent for hospitals in MSAs with a population of one million or more.

Other adjustments Payment rates also may be adjusted to reflect higher costs of care in hospitals that operate approved resident training programs, revenue losses associated with treating low-income patients, and the financial burden of exceptionally high-cost cases. These adjustments are intended to preserve access to care for Medicare beneficiaries by protecting hospitals that face

certain cost or revenue pressures.¹¹ Medicare also makes special payments designed to help rural hospitals, although some urban facilities also may qualify.¹² These include provisions for sole community hospitals, rural referral centers, and small Medicare-dependent hospitals. Certain rural hospitals qualify for cost-based payment as critical access hospitals (CAHs) and are no longer covered by the inpatient PPS. Eligible hospitals may qualify for capital exceptions payments if they meet project size, need and, for certain urban hospitals, excess capacity tests, or if they incur extraordinary capital expenditures in excess of \$5 million.

The MMA includes several provisions to aid rural hospitals. It allows CAHs to use up to 25 beds for acute patients, an increase from the prior limit of 15 acute beds. The provision also curtails hospitals' ability to convert to critical access hospital status starting in 2006. It also creates a low-volume adjustment for rural hospitals that are more than 25 miles from another hospital. Facilities with fewer than 800 discharges from all payment sources may qualify for this payment add-on.

Medical education payments Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with operating approved physician training programs. The size of the indirect medical education (IME) adjustment applied to DRG payments depends on the hospital's teaching intensity, as measured by the number of residents per bed. In 2004, approximately

¹¹ Medicare also reimburses acute-care hospitals for bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. The Balanced Budget Act of 1997 reduced these payments, but BIPA added some back. As a result, Medicare paid 70 percent of allowable bad debts in fiscal year 2004.

¹² These special payment provisions are discussed in greater detail in MedPAC's June 2001 Report to the Congress.

1,100 hospitals received IME payments; nearly 95 percent of those facilities were located in urban areas, although they served Medicare beneficiaries living in both urban and rural areas. The MMA temporarily raises indirect medical education payments, with a four-year phase-down to an adjustment rate slightly below the current rate. Medicare makes payments for the direct costs of operating graduate medical education (GME) programs based on hospital-specific costs per resident in a base year. The MMA freezes per resident payment amounts for hospitals that currently have per resident amounts that are more than 140 percent of the national average.

Disproportionate share payments Hospitals that treat a disproportionate share (DSH) of low-income patients receive additional payments that are intended to partially offset their revenue losses from furnishing uncompensated care. As amended by the MMA, the DSH adjustment is based on five different formulas and depends on urban or rural location, number of acute care beds, and rural referral center status.¹³ The amount of the adjustment—the add-on percentage from the applicable formula—depends on the hospital's low-income patient share. A hospital's low-income patient share is the sum of the proportion of its Medicare inpatient days furnished to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. No DSH payments are made unless a hospital's low-income patient share exceeds 15 percent.

The MMA increased the maximum disproportionate share add-on from 5.25 percent to 12 percent of base inpatient payments for most rural hospitals and small urban hospitals.

¹³ A special adjustment rate applies to hospitals that receive at least 30 percent of their inpatient revenue from state and local government subsidies.

Outlier payments In general, hospitals are expected to offset losses on some cases (in which costs exceed the payment rate) with gains on others (in which costs are below payments). Some cases, however, are extraordinarily costly, producing losses that may be too large to offset. Hospitals facing fixed payment rates have strong financial incentives to avoid patients who may be likely to require extraordinary care. To promote access to high-quality inpatient care for seriously ill beneficiaries, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital DRG payments.

Outlier cases are identified by comparing their costs to a DRG-specific threshold that is the sum of the hospital's DRG payment for the case (both operating and capital), any IME and DSH payments, and a fixed loss amount. For instance, in 2004 the threshold is set at the hospital's DRG payment plus any IME, DSH, and new technology add-on payments plus \$31,000—the national fixed loss amount—adjusted to reflect input price levels in the hospital's local market. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds (90 percent for burn cases). Costs for individual cases are estimated by reducing the hospital's covered charges for the case by its overall Medicare cost to charge ratio from its most recent tentatively settled annual cost report. IME and DSH adjustments are not applied to outlier payments. Outlier payments were funded in 2004 by offsetting reductions in the operating base payment amounts (5.1 percent) and the capital federal rate (4.8 percent).

Transfer policy Medicare reduces DRG payments when the patient is transferred to another PPS hospital, or in some instances to a post-acute care setting. When a patient is transferred to another PPS hospital, the transferring facility is paid a per diem amount for each day before the transfer occurs, up to a

maximum of the full DRG payment.¹⁴ The hospital receiving a transferred patient is paid according to the appropriate DRG, which may or may not be the same as the DRG assigned in the preceding hospital stay, as if the case had not been transferred.¹⁵ Discharges in 29 DRGs are treated as transfers if patients are sent to a long-term care hospital or a rehabilitation, psychiatric, or skilled nursing facility, or they receive clinically related home health care.

Payment updates Both the operating and capital payment rates are updated annually. The Congress sets the operating update in law; the Secretary determines the annual capital update. The MMA increases inpatient payments by the projected increase in the market basket index in fiscal years 2005 through 2007. However, payments to hospitals that fail to provide data on specified quality indicators will be reduced by 0.4 percent.

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¹⁴The per diem rate is the hospital's DRG payment rate divided by the national average length of stay for the same DRG. 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 DRG rate. Hospitals may also receive outlier payments calculated using a loss threshold prorated to reflect the length of stay.

¹⁵If the patient is discharged to another PPS hospital, the transfer payment rules again apply.