HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: January 2021

Medicare beneficiaries receive inpatient care in over 3,200 short-term acute care hospitals paid under the inpatient prospective payment system (IPPS).[1] Medicare's acute 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. Beneficiaries are liable for a deductible for the first hospital stay in an episode, for daily copayments on the 61st to 90th day of the episode, a higher daily copayment for lifetime reserve days used beyond the 90th day of the episode, and all costs once lifetime reserve days have been exhausted.[2]

In fiscal year 2019, the Medicare program and its beneficiaries spent $111 billion on inpatient services covered under the IPPS. In addition, the Medicare program made $8.1 billion in uncompensated care payments to IPPS hospitals.[3]

Defining the inpatient acute care that Medicare buys

The IPPS primarily pays fixed per discharge rates covering operating and capital expenses during an inpatient illness episode. (Certain costs are excluded from the per discharge payments and paid separately, such as the direct costs of operating graduate medical education programs and organ acquisition costs.)[4]

Facing fixed inpatient 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. For example, 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. Similarly, payment is reduced when patients have a short length of stay and are transferred to another acute care hospital or, in certain cases, when patients are discharged to post-acute care settings.

Setting the payment rates

Medicare's per discharge IPPS payments are derived through a series of adjustments applied to separate operating and capital base payment rates (Figure 1). The two base rates are adjusted to reflect geographic factors, patient case mix, facility characteristics, and other factors recognized under Medicare's payment system.

The base payment amounts Medicare sets operating and capital per discharge IPPS base rates (known as standardized payment amounts). Operating base payments are tied to labor and supply costs; capital base payments are tied to costs for depreciation, interest, rent, and property-related insurance and taxes. For fiscal year 2021, the operating base rate is $5,961 and the capital rate is $466.

Adjustment for geographic factors 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 and labor-related costs. To determine the wage index for each metropolitan statistical area and statewide rural area, CMS compares the average hourly wage for employees of hospitals in that area to the nationwide average, after controlling for differences in hospitals' occupational mix, and then applies certain adjustments.

The wage index for the area in which the hospital is located—or granted assignment to—is applied to the hospital's IPPS base rates.[5] For operating base rates, the wage index is applied the portion of

The policies discussed in this document were current as of September 15, 2020, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. Several numbers were updated in January 2021. This document does not reflect proposed legislation or regulatory actions.

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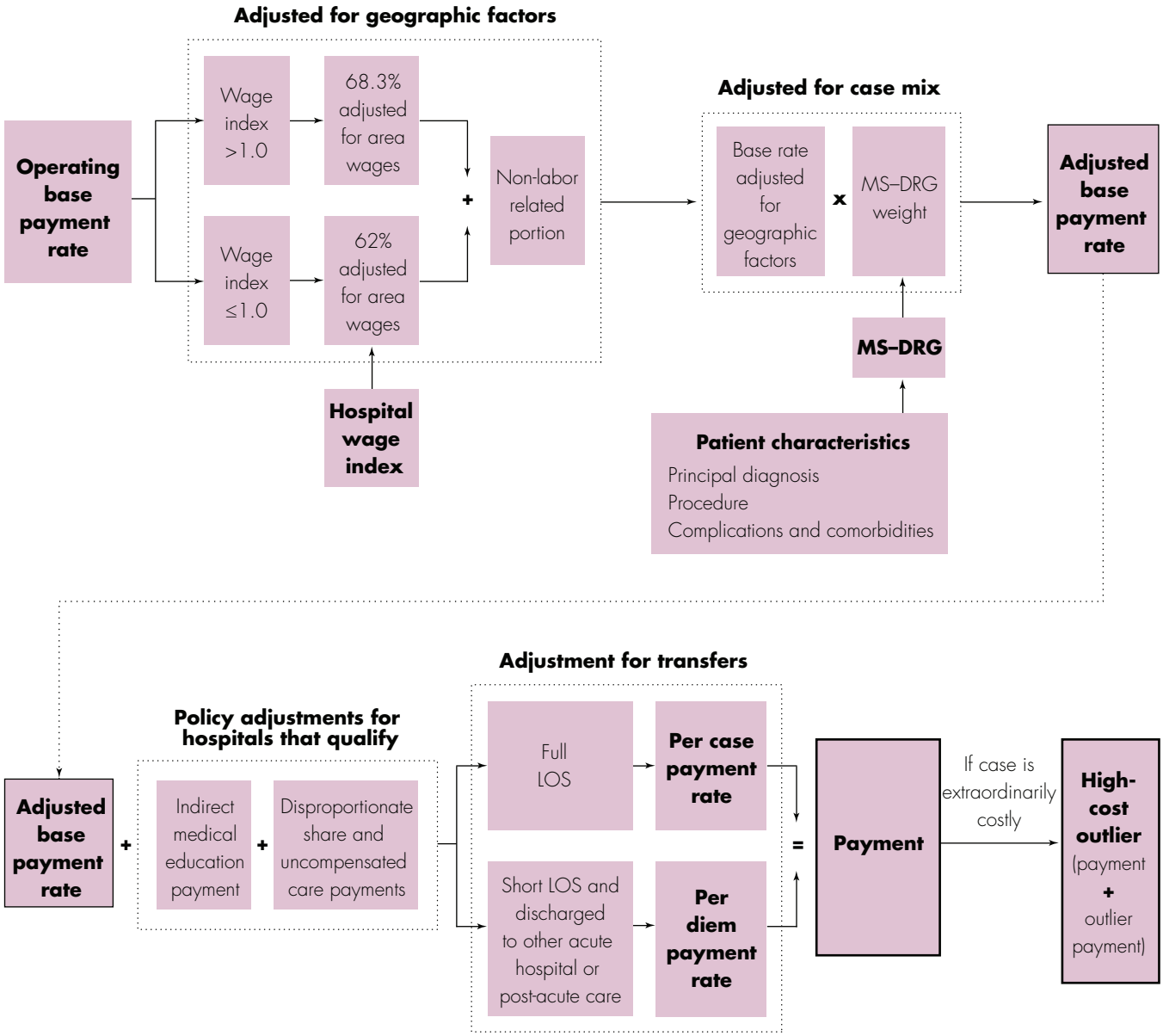
Figure 1 Acute inpatient prospective payment system for fiscal year 2021



Note: MS–DRG (Medicare severity diagnosis related group), LOS (length of stay). Capital payments are determined by a similar system. Additional payments are also made for certain rural hospitals. Hospitals may receive penalties or additional payments based on their performance on quality standards.

the base rate attributable to wages and wage-related costs. This operating labor share is set by statute at 62 percent for hospitals with a wage index less than or equal to 1, and estimated by CMS for those with a wage index above 1.[6] For capital base rates, a factor based on the wage index is applied to 100 percent of the capital base rate.

Both the operating and capital rates are also subject to a cost-of-living adjustment reflecting the higher costs of supplies and other nonlabor resources in Hawaii and Alaska.

Adjustment for case mix The geographic-adjusted operating and capital rates are then adjusted for case mix to reflect the patient's condition and expected costliness. To determine the case-mix adjustment, Medicare assigns discharges to Medicare severity diagnosis related groups (MS–DRGs), which are primarily 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 25 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 25 procedures performed during the stay. In 2021, the MS–DRG system included 338 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, resulting in a total of 767 MS–DRGs.

Each MS–DRG has a relative weight that reflects the expected costliness of inpatient treatment for patients in that group relative to the expected costliness across all patient groups.

Indirect medical education payments Hospitals that train residents receive additional operating and capital IPPS payments to offset the additional (indirect) costs of patient care associated with resident training. These indirect medical education (IME) payments are calculated as a percentage add-on to geographic– and case-mix–adjusted base rates. The size of the IME percentage add-on depends on the hospital's teaching intensity, defined as the hospital's allowed number of residents per inpatient bed (for operating IME) or allowed residents per average daily inpatient census (for capital IME).

Disproportionate share and uncompensated care payments Hospitals that treat a disproportionate share (DSH) of certain low-income patients receive additional operating and capital payments intended to offset the financial effects of treating these patients. DSH payments are calculated as a percentage add-on to geographic– and case-mix–adjusted base rates. The size of the DSH percentage add-on depends on the hospital's low-income patient share, defined as 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. Any hospital with a low-income share exceeding 15 percent is eligible to receive operating DSH payments based on a complex formula, which caps the operating DSH percentage add-on at 12 percent for most small or rural hospitals. (To be eligible for capital DSH payments, hospitals must also be urban and have 100 or more beds.)

Pursuant to a provision in the Affordable Care Act of 2010 (ACA), beginning in 2014, each eligible hospital receives (1) a reduced operating DSH payment and (2) an uncompensated care payment. Under the revised operating DSH payment equation, hospitals receive 25 percent of the DSH funds they would have received under prior law. Second, each hospital receives uncompensated care payments equal to its share of a fixed pool of dollars defined as 75 percent of estimated aggregate operating DSH payments under the prior-law DSH formula multiplied by the national uninsured rate as a percentage of the uninsured rate in 2013. This is referred to as the uncompensated care pool. In fiscal year 2021, the uncompensated care pool will be $8.3 billion dollars and allocated to DSH hospitals based on their share of reported uncompensated care costs in 2017 relative to all other hospitals receiving DSH payments. (Capital DSH payments are based completely on the prior-law DSH formula and do not include a component based on uncompensated care.)

Transfer policy To counter providers' financial incentives to reduce their inpatient costs by moving some services to another setting, 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 and:

- are either transferred to another hospital covered by the IPPS or designated as a critical access hospital, or
- for certain DRGs, discharged to a post-acute care setting.[7]

Under this policy, transferring facilities 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.[8]

New technology payments Hospitals with cases treated using certain new and expensive technologies receive add-on payments to offset the costs of these new technologies. CMS evaluates applications for new technology add-on payments (NTAP) submitted by technology firms and others based on criteria of newness, substantial clinical improvement, and the cost of the technology exceeding MS–DRG–specific thresholds. For cases involving eligible new technologies, NTAPs are generally set at 65 percent of the lesser of (1) the costs of the new technologies or (2) the amount by which the costs of the case exceed the otherwise applicable IPPS operating payment (including IME and DSH).

Outlier payments Medicare makes extra payments for cases that are extraordinarily costly.

High-cost outlier cases are identified by comparing the cost of that case to a threshold that is the sum of the hospital's:

- geographic– and case-mix–adjusted base payment for the case (both operating and capital),
- any IME, DSH, uncompensated care, and new technology payments, and
- a fixed-loss amount (subject to geographic and transfer adjustments, as applicable).

For each case that exceeds the threshold, Medicare makes an outlier payment equal to 80 percent of the hospital's costs above the threshold (or 90 percent for burn cases).

Outlier payments are financed by prospective offsetting reductions in the operating base rate and the capital base rate. CMS sets the national fixed-loss amount at the level it estimates will result in outlier payments equaling the target operating offset of 5.1 percent. In 2021, the national fixed-loss amount is $29,064. There was also a 5.3 percent offset to the capital base rate to fund capital outlier payments.

Special payments for rural or isolated hospitals Medicare makes additional payments to certain rural or isolated hospitals.

Sole community hospital payments— The sole-community hospital (SCH) designation is for hospitals that are located at least 35 miles from the nearest short-term acute care hospital, or that are located in a rural area and meet criteria related to isolation. These hospitals receive operating payments equal to the higher of payments under the IPPS or payments based on their costs per discharge in a base year updated to the current year and adjusted for their current year case mix.

Medicare-dependent hospital payments— The Medicare-dependent hospital (MDH) program is for small, rural hospitals not designated as a SCH in which Medicare patients comprise at least 60 percent of their admissions or patient days. These hospitals receive operating payments equal to IPPS payments plus 75 percent of the difference between those payments and payments based on their updated base-year costs.

Low-volume hospital payments—The low-volume hospital designation is for hospitals that have a low number of discharges and meet criteria related to isolation. For fiscal years 2019 to 2022, to be eligible a hospital must have fewer than 3,800 total discharges and be

located more than 15 road miles from the nearest hospital (excluding critical access hospitals and Indian Health Service hospitals). These hospitals receive up to a 25 percent increase in their IPPS payments (including geographic– and case-mix–adjusted operating and capital base payments, and any IME, DSH, uncompensated care, new technology, outlier, SCH, or MDH payments).

Quality incentive payments and penalties

Excess readmissions penalty—Under the hospital readmissions reduction program implemented in fiscal year 2013, hospitals that have excess Medicare readmissions for selected conditions have their adjusted operating base payments reduced by up to 3 percent. In fiscal year 2021, the readmissions policy applies to six conditions (acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, total hip and knee arthroplasty, and coronary artery bypass graft).

Value-based incentive payments—Under the value-based incentive payment program implemented in fiscal year 2013, CMS redistributes a pool of dollars equal to 2 percent of adjusted operating base payments based on performance on a set of outcome, patient experience, safety, and efficiency measures.

Hospital-acquired conditions penalty—Under the hospital-acquired condition reduction program implemented in fiscal year 2015, hospitals are ranked on their total rate of preventable conditions such as falls, surgical site infections, and catheter-associated urinary tract infections. The 25 percent of hospitals with the highest rates of preventable conditions receive a 1 percent reduction in all inpatient payments.

Payment rate updates

CMS makes several annual updates to IPPS payment rates, including updates to the base rate, wage index, MS–DRG definitions and weights, and the outlier fixed-loss amount.

IPPS base rates are updated annually primarily based on the applicable market basket index and estimates of changes in productivity. For 2021, the operating base rate reflects an annual update of 2.4 percent. The update is the sum of the hospital market basket (which measures the price increase of goods and services hospitals buy to produce patient care) of 2.4 percent, less the current 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity of 0.0 percentage points.[9] In addition, the 2021 operating base rate was subject to a 0.5 percentage point increase required by the Medicare Access and CHIP Reauthorization Act, as well as annual budget neutrality adjustments. The Secretary determines the annual update to the capital payment rate based on the capital market basket and other factors. In 2021, the update to the capital base rate reflected an annual update of 1.1 percent. ■

1 Over 1,300 rural hospitals qualify as critical access hospitals and are paid on a reasonable cost basis instead of under the IPPS. The *Critical Access Hospitals Payment System* document in our "Payment Basics" series provides more information on this topic. Short-term acute care hospitals in Maryland or territories other than Puerto Rico, children's hospitals, and cancer hospitals are also exempt from the IPPS and paid under other methodologies.

2 Medicare pays the approved amount minus any beneficiary liability, such as a deductible or copayment; the provider then needs to collect the remaining amount from the beneficiary or a supplemental insurer. In 2021, the inpatient deductible was $1,484 per episode and the daily co-payments were $371 from the 61st to 90th day of an episode and $742 per lifetime reserve day. Medicare reimburses providers 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.

3 This spending reflects the post-sequester rates set by the IPPS, including any applicable beneficiary cost-sharing responsibilities. It does not account for any potential unreimbursed bad debt. IPPS hospitals also receive other payments from the Medicare program outside of the IPPS.

4 Medicare pays separately for the direct costs of operating approved training programs for medical, osteopathic, dental, or podiatric residents. These direct graduate medical education (GME) payments are based on hospital-specific costs per resident in a base year, the number of allowed residents, and Medicare's share of inpatient days. Organ acquisition and certain other costs are reimbursed on a reasonable cost basis.

5 A hospital may request geographic reclassification to an adjacent market area for its wage index. Roughly 30 percent of hospitals were approved for reclassification in 2021.

6 From 2018 through 2021, CMS estimated the labor share among hospitals with a wage index greater than 1 to be 68.3 percent.

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

8 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.

9 Hospitals that fail to provide data on specified quality indicators or be meaningful users of electronic health records only receive a fraction of the IPPS operating market basket update.