This Appendix describes the following Medicare payment systems:

- **Inpatient**
- **Direct GME**
- **Bad Debt**
- **Outpatient**
- **Skilled Nursing**
- **Home Health**

APPENDIX: MEDICARE PAYMENT SYSTEMS

Inpatient Payment

Total Medicare payments provide the largest single source of hospitals' revenues—projected to be 30.5% of 2002 overall revenues, or $145.9 billion.[1] Medicare payments for just inpatient care ($87.0 billion in 2000 and forecast to be $98.7 billion in 2002) account for the largest component—about 41%—of Medicare spending.

Since 1984, Medicare has paid for a majority of inpatient hospital service (87% in 2001)[2] under a prospective payment system (PPS) which pays a predetermined per-discharge rate. The concept behind a PPS is that it encourages the hospital to operate efficiently by paying the same base amount to all hospitals for similar cases. While case costs and length of stay will vary, costs under a PPS tend toward an average. It is expected that the gains hospitals incur for low-cost cases will offset losses for high-cost cases, assuming patient volume is sufficient. Each discharge is classified under one of over 500 diagnosis-related groups (DRGs) which group clinically-similar patients requiring similar amounts of hospital resources. DRGs represent per-discharge payments for distinct treatment episodes primarily based on patients' clinical conditions and treatment strategies. A relative weight is calculated for each DRG based on average charges for Medicare cases assigned to the DRG relative to the average charge for all Medicare cases, and represents the relative difference in what a hospital would be paid for operating and capital expenses for different types of cases.

Operating Payments

Operating expense payments are made to cover labor and supply costs. The DRG weighting is applied to one of two separate standardized amounts: one for large urban areas with a population of one million or more, and one for all other urban and rural areas ($4,157 and $4,091, respectively, for fiscal year 2002). The labor and non-labor portions of the standardized amount are adjusted for relative market cost conditions—the labor portion by a wage index and, in Alaska and Hawaii, the non-labor portion by a cost of living adjustment (COLA).

[1] CMS, Office of the Actuary.

[2] CMS, Office of the Actuary. Includes basic operating, capital, indirect medical education, and disproportionate share payments.

Example:
To demonstrate the federal operating rate determined by the DRG calculation prior to any other adjustments, assume that a hospital in a non-large urban area in Michigan, such as Ann Arbor, treats a Medicare beneficiary with a complicated peptic ulcer, DRG 176.

The formula works as follows:

Step 1: Select appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other.

The Standardized amount would be $4,091 for fiscal year 2002. $2,909 is the labor related portion (71.1%), $1,182 is the non-labor related portion.

Step 2: Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located and add back the non-labor portion to calculate the adjusted standardized amount.

Labor-related portion of the standardized amount	*$2,909*
Ann Arbor Wage Index	x *1.1098*
Adjusted labor-related portion	*$3,228*
Non-labor-related portion	+ *$1,182*
Adjusted standardized amount	*$4,410*

Step 3: Multiply the adjusted standardized amount by the relative weight corresponding to the appropriate DRG.

Adjusted standardized amount	*$4,410*
DRG # 176 Complicated Peptic Ulcer	x *1.0888*
Federal Rate	***$4,802***

The federal operating rate paid to the hospital for this discharge would be $4,802. A capital component is calculated that adjusts market input costs in a manner comparable to the steps above and is added to the federal operating rate (see an explanation of capital payments below). Other adjustments for other costs are also made. These are also described below.

Capital Payments

DRG payments also include an amount to pay hospitals for a portion of their capital expenditures and, like operating payments, are prospective. The base capital rate for discharges from hospitals in large urban areas for fiscal year 2002 is $402 and is $391 for hospitals located in other areas. The federal rate for capital payments is adjusted to reflect differing market input costs, also based on the area wage index, and, for Alaska and Hawaii, reflects the COLA.

Other Adjustments

In addition to classifying each operating and capital DRG payment to reflect population size and adjusting for differing market input costs, other adjustments are made to reflect unusually high-cost cases (outliers), the higher costs associated with resident training programs (Indirect Medical Education or IME), and revenue losses from treating low-income patients (disproportionate share or DSH).

Indirect Medical Education
Teaching hospitals, those that train resident physicians, receive an additional payment to cover the additional and indirect costs of this education. The IME adjustment depends on the hospital's teaching intensity, which is calculated by the number of residents per hospital bed. In 2001 more than 1,100 hospitals received IME payments. (See discussion of Direct Graduate Medical Education below.)

Disproportionate Share
Medicare makes payments to hospitals that treat a disproportionate share of low-income patients in order to offset losses from treating these patients The formulas and criteria to determine the adjustment factor are complex, but a hospital meets the threshold for DSH payment if its low-income patient share exceeds 15%. The low-income patient share is calculated by adding: (i) the proportion of a hospital's Medicare inpatient days to the number of patients eligible for Supplemental Security Income benefits[3] to (ii) the proportion of a hospital's total acute inpatient days furnished to Medicaid[4] patients.

$$\text{Disproportionate Share Threshold (\%)} = \frac{\text{Medicare Patients Eligible for SSI}}{\text{Medicare Inpatient Days}} + \frac{\text{Medicaid Inpatient Days}}{\text{Total Acute Inpatient Days}}$$

Until 2001, more than 1,400 of 1,800 DSH hospitals were in large urban areas. The Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Patient Protection Act of 2000 (BIPA) leveled the qualifying threshold for DSH between rural and urban hospitals. BIPA expanded eligibility for DSH payments from about 1,800 hospitals to about 2,900 hospitals; about 800 of the newly eligible facilities were in rural areas. Most rural hospitals, however, have a cap on their DSH adjustment of 5.25%. Large urban hospitals (100 beds or more) and very large rural hospitals (500 beds or more) have no cap.

Outlier Payments
Under inpatient PPS, clinically similar cases are classified into DRGs. Each case in a given DRG is paid the same base amount. While case costs vary depending on factors such as patient acuity and length of stay, payments under a PPS are based on the average cost of cases. For cases that generate extremely high costs relative to similar cases, Medicare makes additional outlier payments to offset the financial impact to hospitals. These payments are based on costs, or charges as adjusted by a hospital's cost-to-charge ratio (CCR).

Medicare pays for most inpatient cases solely based on DRG classification and CCRs do not cause different DRG payments from hospital to hospital. CCRs do, however, affect outlier payment because cost is incorporated into payment calculation for these cases.

[3] Supplemental Security Income is a means-tested benefit for people who are 65 years or older, or blind, or disabled who do not have many assets or much income. Many states add supplemental funds to this Federal benefit.
[4] Medicaid is a jointly-funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

Gross charges[5] are reduced to cost by multiplying by a CCR. Cost is used to determine whether a case qualifies for outlier payment, as well as the outlier payment amount. Fiscal intermediaries calculate a CCR for each hospital, by dividing total costs (based on the latest available settled cost reports for that hospital) by total charges (for the same period covered by the cost reports).[6] Under current policy, if a hospital's CCR falls outside three standard deviations from the national average, the hospital is assigned the state's average CCR.[7] This policy is subject to change by administrative action.

For a case to qualify for an outlier payment, the case cost must exceed the sum of the total DRG payment rate for that case plus a fixed loss threshold. In fiscal 2003, the fixed loss threshold is $33,560. CMS pays 80% of the case cost in excess of the sum of the DRG payment plus the threshold.

Example:
To demonstrate the outlier payment, consider a patient who has undergone resection of a tumor on a pituitary gland (DRG 286) at a generic hospital in San Francisco, California, a large urban area. This patient experienced complications that caused billed charges to total $100,000.

Step 1: Determine the federal payment (including both operating and capital payment rates) with IME and DSH adjustments for the DRG that are specific to this hospital.

The total federal payment rate for DRG 286 at this San Francisco hospital is $15,217.38 ($14,007.26 operating rate plus $1,210.13 capital rate).[8]

Federal Rate for Operating Costs	=	DRG Relative Weight	x	[(Labor Related Large Urban Standardized Amount x San Francisco MSA Wage Index) + Nonlabor Related National Large Urban Standardized Amount]					x	(1 + IME + DSH)
$14,007.26	=	2.0937	x	[($3,022.60 x 1.4142) + $1,228.60]					x	(1 + 0.0744 + 0.1413)

Federal Rate for Capital Costs	=	DRG Relative Weight	x	Federal Capital Rate	x	Large Urban Add-On	x	Geographic Cost Adjustment Factor	x	(1 + IME + DSH)
$1,210.13	=	2.0937	x	$407.01	x	1.03	x	1.2679	x	(1 + 0.0243 + 0.0631)

Step 2: Determine the costs for this case by adjusting the gross (*i.e.*, billed) charges by this hospital's cost-to-charge ratio.

Multiplying the gross charge of $100,000 by the provider-specific cost-to-charge ratio of 0.78 (0.72 operating CCR and 0.06 capital CCR) results in total cost of $78,000.

Operating Costs	=	Billed Charges	x	Operating Cost-to-Charge Ratio
$72,000	=	$100,000	x	0.72
Capital Costs	=	Billed Charges	x	Capital Cost-to-Charge Ratio
$6,000	=	$100,000	x	0.06

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[5] Gross charges, also called billed charges, are the "list prices" for procedures according to a "chargemaster" list maintained by every hospital. All payors are billed by the same chargemaster, but the chargemaster does not reflect privately negotiated discounts given to preferred managed care organizations.
[6] The CCRs used in calculation of 2003 inpatient PPS payments are based on cost reports filed in fiscal 1998 and 1999. Fiscal intermediaries update cost-to-charge ratios annually.
[7] CMS calculates thresholds for each fiscal year. For fiscal 2003, the operating CCR thresholds are 0.194 (minimum) and 1.258 (maximum) and the capital CCR thresholds are 0.012 (minimum) and 0.163 (maximum).
[8] Some figures in this example do not add due to rounding.

Step 3: Compare the total case cost to the sum of the federal payment rate and the fixed loss threshold of $33,560 for fiscal 2003. If the total case cost is greater than this sum, this case qualifies for outlier payment.

Because the total case cost of $78,000 exceeds the sum of the DRG payment ($15,217.38) and the outlier threshold ($33,560), this case qualifies for outlier payment.

Outlier payment for cases in which…	Case Costs	>	Federal Payment Rate	+	Outlier Threshold
	$78,000	>	$15,217.38	+	$33,560

Step 4: If the case qualifies for outlier payment, determine the payment amount. The outlier payment is 80% of the difference between the total case cost and the sum of the federal payment rate and the $33,560 threshold. These calculations are made separately for operating and capital payment. The total case payment is the sum of the DRG payment and the outlier payment.

The outlier payment equals $15,447.84, which is 80% of the difference between the DRG payment and outlier threshold for both operating and capital costs. The hospital receives both the outlier payment and the DRG 286 payment ($15,217.38) for a total case payment of $30,665.22.

Operating Outlier Threshold	=	{[Fixed Loss Threshold x ((Labor related portion x San Francisco MSA Wage Index) + Nonlabor related portion)]	x	(Operating CCR / Total CCR)}	+	Federal Payment with IME and DSH
$54,108.75	=	{[$33,560 x ((0.711 x 1.4142) + 0.289)]	x	(0.72 / 0.78)}	+	$14,007.26

Capital Outlier Threshold	=	{Fixed Loss Threshold	x	Geographic Adj. Factor	x	Large Urban Add-on	x	(Capital CCR / Total CCR)}	+	Federal Payment with IME and DSH
$4,581.45	=	{$33,560	x	1.2679	x	1.03	x	(0.06 / 0.78)}	+	$1,210.13

Outlier payment	=	[(Operating Costs – Operating Outlier Threshold)	+	(Capital Costs – Capital Outlier Threshold)]	x	Marginal Cost Factor
$15,447.84	=	[($72,000 – $54,108.75)	+	($6,000 - $4,851.45)]	x	0.80

Total payment	=	DRG payment	+	Outlier payment
$30,665.22	=	$15,217.38	+	$15,447.84

Estimated total outlier payments are limited by regulation to 5.1% of total DRG payments. Budget neutrality is therefore achieved by a 5.1% reduction to the standardized amount.[9] In setting the fiscal 2003 rates, CMS calculated that previous years' outlier payments exceeded the 5.1% limit. CMS estimated that for fiscal 2002 an outlier threshold of $30,525 would have resulted in outlier payments equal to 5.1% compared to the actual threshold of $21,025. To correct this in fiscal 2003, Medicare increased the outlier threshold to $33,560.

Year	Fixed Loss Threshold (Actual)	Threshold that would have equaled outlier payments as 5.1% of total DRG payments	Outlier payments as percent of total DRG payments
2000	$14,050	$21,825	7.6%
2001	$17,550	$26,200	7.7%
2002	$21,025	$30,525 (est.)	6.9% (est.)
2003	$33,560	$33,560 (est.)	5.1% (est.)

[9] By statute, outlier payments as a percent of total DRG payments must be between 5 and 6%. The reduction to the standardized amount must equal to the estimated outlier percentage to achieve budget neutrality.

Direct Graduate Medical Education (GME) Payment

Every hospital that trains residents in an approved residency program is entitled to receive Medicare direct graduate medical education payment. The direct graduate medical education payment is different for each hospital. It is based on an amount known as the hospital specific per resident amount. The hospital specific amount was determined for each teaching hospital in the 1980's and has been updated by an inflation factor since. It covers the direct costs of training residents, such as residents' salaries, teaching physicians' salaries, and related overhead expenses. For each hospital receiving direct medical education payment, Medicare pays a portion of the hospital specific per resident amount. Although the payments are made using different formulas, the hospital's direct and indirect medical education payments will vary based on the number of residents (allopathic, osteopathic, dentistry and podiatry) a hospital trains. That is, a hospital training more residents will receive higher direct and indirect medical education payments. In general, 1,154 teaching hospitals participated in the Medicare program in 1999 to receive direct and indirect medical education payments. CMS projects that Medicare will make over $9 billion in direct GME payments and IME payments combined in 2002 to teaching hospitals. Total payment for physicians' services during 2002 are projected to be $42.7 billion, making GME 17.4% of the sum of total physicians' services and GME.

Bad Debt Reimbursement

Hospitals that provide health care to Medicare beneficiaries sometimes incur bad debt because of beneficiary failure to pay deductibles and coinsurance (D&C). In some instances, Medicare will reimburse hospitals for this bad debt. The reimbursement depends on the method by which an entity is paid for providing services. Hospitals must show that they have made a reasonable effort to recover the D&C before considering it unrecoverable.

Outpatient Payment

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to surgical procedures. Spending for these services is growing rapidly because of changes in technology and medical practice that have shifted care from inpatient to ambulatory care settings. Outpatient hospital care accounted for about 7% of total Medicare spending in 2000, or about $17 billion.

The outpatient PPS, implemented in August 2000, sets payment rates for services based on a set of relative weights, a conversion factor, and an adjustment for geographic differences in input prices. In requiring the outpatient PPS, the Congress also reduced beneficiary copayments for outpatient hospital care, which were about 50% of total Medicare payments to hospitals for outpatient care when the BBA was enacted.

Ambulatory Payment Classifications (APCs)
CMS classified procedures, evaluation and management services, drugs and devices in outpatient departments into about 750 ambulatory payment classifications (APCs). These APCs group items and services that are clinically similar and use comparable resources. Within each APC, CMS bundles integral services and items with the primary service. For example, a surgical procedure includes operating and recovery room services, anesthesia, and surgical supplies. More than 300 of the APCs identify drugs or devices used in conjunction with a procedure. In addition, some new services are assigned to certain new technology APCs while CMS collects the clinical and cost data necessary to incorporate them into a clinically appropriate APC.

The APC groups and their relative weights are reviewed and revised annually to account for changes in medical practice, technology, services, cost data, and other relevant information. CMS also annually updates the conversion factor by the hospital market basket index.

Setting Product Payment Rates
Payment rates in the outpatient PPS cover hospitals' operating and capital costs. Professional services such as physicians' services provided to individual patients are paid separately. Outpatient payment rates are determined by multiplying the relative weight for an APC by a conversion factor. Except for the new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. The conversion factor translates the relative weights into dollar payment amounts. The initial conversion factor was set so that projected total payments— including beneficiaries' copayments— would equal the estimated amount that would have been spent under the old payment methods, after correcting for some anomalies in statutory formulas. Payments are adjusted for geographic wage variations using the inpatient PPS wage index values.

The outpatient PPS also includes the following four additional payment adjustments:

Passthrough Payments for New Technology
Pass-through payments are payments for certain new technology items, such as drugs, biologicals, and devices that were not represented in the 1996 data that CMS used to set the PPS payment rates. For drugs and biologicals, the payments are based on average

wholesale prices. For devices, the payments are based on each hospital's costs (as determined by adjusting its charges using a cost-to-charge ratio). By law, total pass-through payments are limited to 2.5% of total payments under the outpatient PPS.

Outlier Payments
Outlier payments are made for services or procedures with costs that exceed the PPS payment rate for their APC group threefold. The statute sets a limit on projected aggregate outlier payments.

Hold-Harmless Payments for Cancer, Children's and Small Rural Hospitals
The BBRA mandated that cancer hospitals and outpatient departments of small rural hospitals be held harmless from financial losses under the PPS. This protection is permanent for cancer hospitals; small rural hospitals are protected until 2003. In addition, the BIPA extended permanent hold-harmless protection to children's hospitals.

Transitional Corridor Payments
Transitional corridor payments are the difference between a hospital's PPS payments and what it would have received under the previous payment policy. The BBRA mandates that these will continue through 2003.

Skilled Nursing Facility Payment

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs). Medicare covers up to 100 SNF days for a given spell of illness.

Approximately 11.3% of SNFs are hospital-based units. According to MedPAC, payments for SNF services are estimated to be less than 2% of hospitals' revenues.

Since 1998, Medicare has paid for SNF services under a PPS which pays a pre-determined per diem rate. Under the PPS, each beneficiary is designated to one for 44 resource utilization groups (RUGs), each containing patients with similar service needs that are expected to require similar amounts of resources. Much like the other PPSs, the RUG rates are computed separately for urban and rural areas and a portion of the total rate is adjusted to reflect labor market conditions in each SNF's location.

The daily rate for each RUG is calculated using the sum of three components:

1) a fixed amount for routine services (such as room and board, linens, and administrative services);
2) a variable amount reflecting the intensity of nursing care patients are expected to require; and
3) a variable amount for the expected intensity of therapy services.

Under the previous cost-based SNF payment system, a cost distinction was made between freestanding SNFs hospital-based SNFs. Under the law, hospital-based SNFs had a higher cost limit than freestanding facilities for the reimbursement of routine services. This distinction was eliminated by the Congress in the BBA of 1997, as the intensity-related component of the RUG system was intended to factor in any higher level in acuity experienced at hospital-based SNFs.

After the nursing facility industry came under financial pressure as a result of the PPS implementation and other BBA of 1997 provisions, Congress passed two acts to provide some relief—BBRA of 1999 and BIPA of 2000. These laws contained provisions to assist providers as they adjusted to the PPS.

The major elements of the add-ons are:

Sec 101 BBRA 1999:

- 20% increase for 15 of the RUGs. This was implemented in April of 2000 and will remain in effect until the implementation of refinements in the current RUG case-mix classification system. It is estimated that once the refinement is complete—and this 20% increase is thus "folded in to the base," or eliminated—Medicare payments to SNFs will be reduced by an estimated $1.0 billion annually.
- 4% across-the-board increase of the adjusted Federal per diem payment rate (the Federal part of the rate), exclusive of the 20% RUG increase. This is a temporary increase, for a duration of two-and-a-half years, from April of 2000 until the end of fiscal year 2002 and is valued at approximately $600 million annually.

Sec. 312 BIPA 2000:

- 16.66% increase in the nursing component of the case-mix adjusted Federal rate. This is a temporary increase, for a duration of eighteen months, from April of 2001 until the end of fiscal year 2002 and is valued at an estimated $1.1 billion annually.
- 6.7% increase in the 14 RUG payments for rehabilitation therapy services. This is an adjustment to the 20% increase granted in BBRA 1999 and spreads the funds directed at 3 of those 15 RUGs to an additional 11 rehabilitation RUGs. This was implemented in April of 2001 and will remain in effect until the implementation of refinements in the current RUG case-mix classification system. It is budget neutral to the total 20% increase in BBRA of 1999.
- Elimination of the BBA of 1997 Market Basket Index reduction of 1.0% for fiscal year 2001. This 1.0% increase provided for higher payments in fiscal year 2001 and was retained in the base rate when CMS applied the update for the fiscal year 2002 rates.

Home Health Payment

Beneficiaries who are confined to their homes and need skilled care are eligible to receive medical services delivered by home health agencies (HHAs) at home. Covered services include: skilled nursing care; physical, occupational, and speech therapy; medical social work; and home health aide services. Beneficiaries are not required to make any copayments for these services. Medicare's payments to HHAs were approximately $9 billion in 2000, accounting for 4% of total Medicare spending.

In October 2000, CMS adopted a new PPS in which HHAs are paid a predetermined rate for each 60-day episode of home health care. Prior to October 2000, HHAs were paid on the basis of their incurred average costs per visit subject to annually adjusted limits.

Payment Rates
Medicare purchases home health services in units of 60-day episodes. The severity of a patient's condition changes the number and type of visits required for care. Patients receiving 5 or more visits are assigned to 1 of 80 home health resource groups (HHRGs) based on diagnosis, functional capacity, and service use. The HHRGs range from groups of relatively uncomplicated patients to those containing patients who have severe medical conditions who need extensive therapy. Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient. The payment rates for HHRGs in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing 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 HHRG.

The initial national average base payment amount for a typical home health episode is intended to reflect the projected amount providers would have received per episode under the previous payment system, updated for inflation. Because providers receive payments on a per-visit basis for patients who are furnished fewer than 5 visits in 60 days, the base amount was adjusted to reflect this policy. It was also reduced 5% to account for anticipated high-cost outlier payments. For fiscal year 2002, the national average payment rates for HHRGs range from $1,137 to $6,368.

The per-episode payment rate is divided into labor and non-labor portions; the labor portion—77%—is adjusted by a version of the hospital wage index to account for geographic differences in the market prices for labor-related inputs to home health services. For home health services the local area adjustment is determined by the beneficiary's residence. The total payment is the sum of the adjusted labor portion and the non-labor portion.

The base rate is updated annually. The update is based on the projected change in the home health market basket, which measures changes in the prices of goods and services home health agencies must buy to produce care.

Rural Payments

As required by BIPA, payment rates are temporarily increased by 10% for care delivered to beneficiaries who live in rural areas. This is intended to compensate for potentially higher visit costs in rural areas related to low patient volume and long distances between patients. This add-on expires for episodes ending after April 1, 2003.

Outlier Payments

When a patient's episode of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an outlier payment. To be eligible, imputed episode costs must exceed the payment rate by 13% or more. Episode costs are imputed by multiplying the estimated national average per visit costs by type of visit by the numbers of visits by type during the episode. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80% of the difference in addition to the episode payment.

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