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#### Acronyms

AHIMA	American Health Information Management Association
AHA	American Hospital Association
CAH	Critical access hospital
CBSAs	Core Based Statistical Areas
CC	Complication or comorbidity
CMS	Centers for Medicare & Medicaid Services
CMSA	Consolidated Metropolitan Statistical Areas
COBRA	Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
CPI	Consumer Price Index
CRNA	Certified registered nurse anesthetist
DRG	Diagnosis-related group
DSH	Disproportionate share hospital
FDA	Food and Drug Administration
FQHC	Federally qualified health center
FTE	Full-time equivalent
FY	Federal fiscal year
GME	Graduate medical education
HIPC	Health Information Policy Council
HIPAA	Health Insurance Portability and Accountability Act, Pub. L. 104–191
HHA	Home health agency
ICD–9–CM	International Classification of Diseases, Ninth Revision, and Clinical Modification
ICD–10–PCS	International Classification of Diseases Tenth Edition, and Procedure Coding System
IME	Indirect medical education
IPPS	Acute care hospital inpatient prospective payment system
IRF	Inpatient Rehabilitation Facility
LDRP	Labor, delivery room, and postpartum
LTC–DRG	Long-term care diagnosis-related group

LTCH	Long-term care hospital
MCE	Medicare Code Editor
MDC	Major diagnostic category
MDH	Medicare-dependent small rural hospital
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Provider Analysis and Review File
MEI	Medicare Economic Index
MGCRB	Medicare Geographic Classification Review Board
MPFS	Medicare Physician Fee Schedule
MSA	Metropolitan Statistical Area
NECMA	New England County Metropolitan Areas
NCHS	National Center for Health Statistics
NCHVS	National Committee on Health and Vital Statistics
O.R.	Operating room
PPS	Prospective payment system
PRA	Per resident amount
ProPAC	Prospective Payment Assessment Commission
PRRB	Provider Reimbursement Review Board
RCE	Reasonable compensation equivalent
RHC	Rural health center
RRC	Rural referral center
SCH	Sole community hospital
SNF	Skilled nursing facility
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
UHDDS	Uniform Hospital Discharge Data Set

#### I. Background

##### A. Summary

##### 1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a

percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. To qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although MDHs receive only 50 percent of the difference between the IPPS rate and their hospital-specific rates if the hospital-specific rate is higher than the IPPS rate).

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services “in accordance with a prospective payment